

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5248

CERTIFICATE OF DEATH

05240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 10		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 124 Woodlawn Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle W Last AISQUITH			4. DATE OF DEATH Month MAY Day 9 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1875		9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE AISQUITH			14. MOTHER'S MAIDEN NAME MARY IRELAND		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lucy B. Tucker- Sister- Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardio Vascular Failure DUE TO (b) Myocarditis & Valvular Disease DUE TO (c) General Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Several yrs					INTERVAL BETWEEN ONSET AND DEATH Several yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from May 7th , 19 58 , to May 9th , 19 58 , that I last saw the deceased alive on May 9th , 19 58 , and that death occurred at 2:10 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE J. Oliver Purvis		ADDRESS (Street, city or town, state) 40 Franklin St., Annapolis Md		DATE SIGNED 5-10-58	
PHYSICIAN'S NAME (Type) J. OLIVER PURVIS M D		40 FRANKLIN STREET ANNAPOLIS 2 MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 12, 1958	22c. NAME OF CEMETERY OR CREMATORY HOPE CHAPEL CEMETERY	22d. LOCATION (City, town, or county) (State) EDGEWATER, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS ANNAPOLIS, MARYLAND		24a. REC'D BY REGISTRAR MAY 13 '58	24b. REGISTRAR'S SIGNATURE Al. Search

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 1914
CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		M		35		1914		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE	
1879		BALTIMORE, MARYLAND		HIGH SCHOOL		METHODIST		MARRIED	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		CHILDREN		PREVIOUS DEATHS	
JAMES H. HARRIS		MARY H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		NONE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		SPOUSE'S OCCUPATION		CHILDREN'S OCCUPATIONS		PREVIOUS DEATHS	
LABORER		LABORER		LABORER		LABORER		NONE	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		SPOUSE'S RESIDENCE		CHILDREN'S RESIDENCES		PREVIOUS DEATHS	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		NONE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		SPOUSE'S DATE OF DEATH		CHILDREN'S DATES OF DEATH		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		SPOUSE'S PLACE OF DEATH		CHILDREN'S PLACES OF DEATH		PREVIOUS DEATHS	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		NONE	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		SPOUSE'S MANNER OF DEATH		CHILDREN'S MANNERS OF DEATH		PREVIOUS DEATHS	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF BURIAL		MOTHER'S PLACE OF BURIAL		SPOUSE'S PLACE OF BURIAL		CHILDREN'S PLACES OF BURIAL		PREVIOUS DEATHS	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		NONE	
FATHER'S DATE OF BURIAL		MOTHER'S DATE OF BURIAL		SPOUSE'S DATE OF BURIAL		CHILDREN'S DATES OF BURIAL		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S MANNER OF BURIAL		MOTHER'S MANNER OF BURIAL		SPOUSE'S MANNER OF BURIAL		CHILDREN'S MANNERS OF BURIAL		PREVIOUS DEATHS	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF INTERMENT		MOTHER'S PLACE OF INTERMENT		SPOUSE'S PLACE OF INTERMENT		CHILDREN'S PLACES OF INTERMENT		PREVIOUS DEATHS	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		NONE	
FATHER'S DATE OF INTERMENT		MOTHER'S DATE OF INTERMENT		SPOUSE'S DATE OF INTERMENT		CHILDREN'S DATES OF INTERMENT		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S MANNER OF INTERMENT		MOTHER'S MANNER OF INTERMENT		SPOUSE'S MANNER OF INTERMENT		CHILDREN'S MANNERS OF INTERMENT		PREVIOUS DEATHS	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF CREMATION		MOTHER'S PLACE OF CREMATION		SPOUSE'S PLACE OF CREMATION		CHILDREN'S PLACES OF CREMATION		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S DATE OF CREMATION		MOTHER'S DATE OF CREMATION		SPOUSE'S DATE OF CREMATION		CHILDREN'S DATES OF CREMATION		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S MANNER OF CREMATION		MOTHER'S MANNER OF CREMATION		SPOUSE'S MANNER OF CREMATION		CHILDREN'S MANNERS OF CREMATION		PREVIOUS DEATHS	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	
FATHER'S PLACE OF REINTERMENT		MOTHER'S PLACE OF REINTERMENT		SPOUSE'S PLACE OF REINTERMENT		CHILDREN'S PLACES OF REINTERMENT		PREVIOUS DEATHS	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND		NONE	
FATHER'S DATE OF REINTERMENT		MOTHER'S DATE OF REINTERMENT		SPOUSE'S DATE OF REINTERMENT		CHILDREN'S DATES OF REINTERMENT		PREVIOUS DEATHS	
NONE		NONE		NONE		NONE		NONE	
FATHER'S MANNER OF REINTERMENT		MOTHER'S MANNER OF REINTERMENT		SPOUSE'S MANNER OF REINTERMENT		CHILDREN'S MANNERS OF REINTERMENT		PREVIOUS DEATHS	
NATURAL		NATURAL		NATURAL		NATURAL		NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

5249

Item 9 Film 6229 6-1-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05241

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 Washington Street				d. STREET ADDRESS 407 Washington Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ANNA M. ALEXANDER (ALSO) MARGUERITE A. PARKIN				4. DATE OF DEATH Month May Day 23 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1892		9. AGE (In years last birthday) 65 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Night Supervisor		11. BIRTHPLACE (State or foreign country) Pittston, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Alexander				14. MOTHER'S MAIDEN NAME Marie Schneider			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-2981		17. INFORMANT Mr. Frederick J. Parkin- Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the gall-bladder and pancreas 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to May 23 , 19 58 , that I last saw the deceased alive on May 20 , 19 58 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Francis I. Codd M.D. Francis I. Codd M.D. 5-24-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Francis I. Codd M.D. Severna Park, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 27, 58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemet		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE MAY 28 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5283

CERTIFICATE OF DEATH

Reg. Dist. No.

05242

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville (Rural)				c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Point 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 1, Box 432 A				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Richard Middle Bailey Last				4. DATE OF DEATH Month May Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1887		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Self - emp.		11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Ralph Bailey, Rock Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ATHEROSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH NONE - UNKNOWN -							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15 , 19 58 , to 5-2 , 19 58 , that I last saw the deceased alive on 4-29 , 19 58 , and that death occurred at 7:40 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 201 B+A BLVD, GLEN BURNIE, MD DATE SIGNED 5-2-58 ACTUAL SIGNATURE Leon C. Perry M.D. PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Nanjemoy Baptist		22d. LOCATION (City, town, or county) (State) Charles County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Hopping Hopping and Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE DeW. Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED ANNIE ARNOLD		AGE 3 months		SEX Female		RACE White		RELIGION Catholic		MARRIAGE Married		EDUCATION None		OCCUPATION None		RESIDENCE 101 N. Lexington St. Baltimore, Md.		DATE OF DEATH May 1, 1928		PLACE OF DEATH Home		CAUSE OF DEATH Diphtheria		MANNER OF DEATH Natural		CERTIFICATE NO. 101	
DATE OF BIRTH Jan. 1, 1928		PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH May 1, 1928		PLACE OF DEATH Home		CAUSE OF DEATH Diphtheria		MANNER OF DEATH Natural		CERTIFICATE NO. 101		DATE OF DEATH May 1, 1928		PLACE OF DEATH Home		CAUSE OF DEATH Diphtheria		MANNER OF DEATH Natural		CERTIFICATE NO. 101					
DATE OF BIRTH Jan. 1, 1928		PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH May 1, 1928		PLACE OF DEATH Home		CAUSE OF DEATH Diphtheria		MANNER OF DEATH Natural		CERTIFICATE NO. 101		DATE OF DEATH May 1, 1928		PLACE OF DEATH Home		CAUSE OF DEATH Diphtheria		MANNER OF DEATH Natural		CERTIFICATE NO. 101					



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

5250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby boy</u> Middle <u>Bains</u> Last <u>Bains</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1958</u>	
9. AGE (In years lost birthday) yrs. <u>20</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Luther Luke Bains, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Arveta Cyrilla Nick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Churchton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 760.5 DUE TO <u>Intracerebral Hemorrhage; Atelectasis</u> 2 hr 15 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/29/1958</u> to <u>5/29/1958</u> , that I last saw the deceased alive on <u>5/29/1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS MD</u> DATE SIGNED <u>5/30/58</u>							
ACTUAL SIGNATURE <u>R. L. Krehen</u>				PHYSICIAN'S NAME (Type) <u>Amie A. Johnson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Matthews</u>		22d. LOCATION (City, town, or county) (State) <u>Shadyside Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Amie A. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063193XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

5251

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A & General Hospit</i>		d. STREET ADDRESS <i>1 Davidsonville Md</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Jeanette</i> Last <i>Bamford</i>		4. DATE OF DEATH Month <i>5-</i> Day <i>13</i> Year <i>19 58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 25. 1909</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) yrs. <i>49</i>
11. BIRTHPLACE (State or foreign country) <i>Hyattsville Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Philip Jones</i>		14. MOTHER'S MAIDEN NAME <i>Isabelle Henderson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give kind or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Warren H. Bamford</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Extensive lung metastases</i> DUE TO (c) <i>Cancer left breast</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>9 months</i> <i>2 1/2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>February 21 1957</i> to <i>May 13 1958</i> that I last saw the deceased alive on <i>May 13 1958</i> , and that death occurred at <i>12:25 AM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Harold R. Bohlman</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Harold R. Bohlman MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>5-15-58</i>	<i>Methodist Church Park</i>	<i>Friendship Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 19 58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Johnson</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5252

CERTIFICATE OF DEATH

05245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A General</u>				d. STREET ADDRESS <u>637 Chase</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>C.</u> Last <u>BEAN</u>				4. DATE OF DEATH Month <u>5-</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-1905</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder, Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry E. Bean</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances S. Bean</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>SEPT</u> , 19 <u>58</u> , to <u>MAY 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>APR 16</u> , 19 <u>58</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>68 FRANKLIN ST.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.		PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> <u>ANNAPOLIS, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county)	(State)	<u>Annapolis Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Skyles Son</u>		ADDRESS <u>Annapolis Md</u>	24a. REC'D BY REGISTRAR DATE <u>MAY 19 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>			

5253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>22.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>22.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>33 Franklin St</i>				d. STREET ADDRESS <i>1 33 Franklin</i>			
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>L.</i> Last <i>Beattie</i>				4. DATE OF DEATH Month <i>May</i> Day <i>9</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-27-1877</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Allegheny Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Harrison L Lutz</i>				14. MOTHER'S MAIDEN NAME <i>Blanche Reynolds</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs Evelyn Lingras</i> (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0 Congestive heart failure</i> DUE TO (b) <i>Myocardial infarction</i> DUE TO (c) <i>20 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>July</i> , 1955, to <i>5/8</i> , 1958, that I last saw the deceased alive on <i>5/8/58</i> , 1958, and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John H. Hedeman</i>				ADDRESS (Street, city or town, state) <i>68 Franklin St Annapolis, Md</i>		DATE SIGNED <i>5/9/58</i>	
PHYSICIAN'S NAME (Type) <i>JOHN H. HEDEMAN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5-11-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Shippensburg Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Saylor Sons</i>				ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 12 '58</i>	
						24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3			
c. LENGTH OF STAY IN 1b 16 16 days				d. STREET ADDRESS 330 L Street S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Children's Center, Laurel, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13. NAME OF DECEASED (Type or print) Frederick Allen Bell				4. DATE OF DEATH May 18 1958			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1952	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR 5 Months		IF UNDER 24 HRS. 18 Hours		IF UNDER 24 HRS. 158 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Henry Bell				14. MOTHER'S MAIDEN NAME Essie Mae Dent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Children's Center, Laurel, Md. Address --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration 351x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Convulsive disorder DUE TO (c) cerebral birth injury							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pyelonephritis mental deficiency							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 2 , 19 58 , to May 18 , 19 58 , that I last saw the deceased alive on May 18 , 19 58 , and that death occurred at 6:15 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilfred R. Ehrmantraut M.D.				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 5/19/58			
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.				CHILDREN'S CENTER, LAUREL, MD. 5/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Mulvan & Schuy Inc ADDRESS 434-P St NW.				24a. REC'D BY REGISTRAR MAY 27 '58		24b. REGISTRAR'S SIGNATURE Alfred Schuy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05248

5285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 21yr. 9m. 25d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore d. STREET ADDRESS 1015 Argyle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mazie Middle Black Last Black		4. DATE OF DEATH Month 5 Day 25 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1905
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Black		14. MOTHER'S MAIDEN NAME Cecila Stuart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration with Gastro-Intestinal Hemorrhage DUE TO (c) Cancer of the Breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 56 to 5/25 19 58 , that I last saw the deceased alive on 5/25 19 58 , and that death occurred at 11/25 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		DATE SIGNED 5/26/58	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-27-58	
22c. NAME OF CEMETERY OR CREMATORY Edmond Wood Chapel		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 Wash, D.C.		24a. REC'D BY REGISTRAR Anna Md.	
24b. REGISTRAR'S SIGNATURE Anna Md.		DATE JUN 2 '58	

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Race of Deceased _____		Marital Status _____	
Place of Birth _____		Usual Residence _____	
Cause of Death _____		Manner of Death _____	
Physician's Signature _____		Coroner's Signature _____	
Date of Signature _____		Date of Signature _____	

RECEIVED FROM

RECEIVED FROM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 229 6-2-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 05249

5254

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Lasio</u> Last <u>Brodanowicz</u>				4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx.</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Joseph Brodanowicz</u>				Address <u>Some St. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO <u>Cerebral atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				20g. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>May 11</u> , 19 <u>58</u> , to <u>May 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 13</u> , 19 <u>58</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D.				ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John Hedeman</u>				DATE SIGNED <u>5/15/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pandalk, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gen Burnie, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director; page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 22 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05250
Item 20 Film 228 5-14-58 ams										
5255										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>3</u>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Academy</u>					d. STREET ADDRESS <u>Annapolis, Maryland</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>Richard Laurence BOGNANNI</u>					4. DATE OF DEATH <u>May 4 19 58</u>					
5. SEX <u>Male</u>					6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>April 25, 1937</u>					
9. AGE (In years last birthday) <u>21</u> yrs.					IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midshipman</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>					
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>John P. BOGNANNI</u>					14. MOTHER'S MAIDEN NAME <u>Lillian Teresa BOGNANNI</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>219 32 7921</u>					
17. INFORMANT <u>U. S. Navy Records</u>					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO (b) <u>Strangulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Investigation Being conducted.</u>										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Man hanged himself with his bathrobe belt</u>										
20c. TIME OF INJURY Month, Day, Year <u>1215 p. m. May 4 19 58</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Dormitory</u>					20f. (City or town) <u>Annapolis, Anne Arundel, Md.</u> (County) (State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1215 PM</u> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Maynard L. Sisler</u>					ADDRESS (Street, city or town, state) <u>U. S. Naval Academy, Annapolis, Md.</u> DATE SIGNED <u>5-5-58</u>					
PHYSICIAN'S NAME (Type) <u>Maynard L. SISLER, LT., MC, USN</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-8-58</u>					22b. DATE THEREOF <u>5-8-58</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>					22d. LOCATION (City, town, or county) <u>BALTO Md</u> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemard J. Kuck</u> ADDRESS <u>5305 Bayford</u>					24a. REC'D BY REGISTRAR <u>DATE MAY 7 58</u>					
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5286

CERTIFICATE OF DEATH

Reg. Dist. No.

05251

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CHARLES ROLAND BRADY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29 - 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>RET. CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES R. BRADY</u>		14. MOTHER'S MAIDEN NAME <u>MARY GABLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>NINA B. BRADY</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>6 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>CARCINOMA OF LUNG WITH PROBABLE BONY METASTASES</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>58</u> , to <u>5/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>58</u> , and that death occurred at <u>1 A.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Richard W. Green</u> M.D.		<u>68 FRANKLIN ST.</u> <u>5/3/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD W. PECKER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		24a. REC'D BY REGISTRAR <u>MAY 5 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Richard W. Green</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED CHARLES HENRY KNOX</p>		<p>2. SEX Male</p>	
<p>3. AGE 34</p>		<p>4. DATE OF BIRTH 10-12-1890</p>	
<p>5. PLACE OF BIRTH WOOD</p>		<p>6. CITY OF BIRTH BALTIMORE</p>	
<p>7. OCCUPATION Clerk</p>		<p>8. PLACE OF DEATH Home</p>	
<p>9. CAUSE OF DEATH Myocardial Infarction</p>		<p>10. MANNER OF DEATH Natural</p>	
<p>11. DATE OF DEATH 10-15-1925</p>		<p>12. TIME OF DEATH 11:00 AM</p>	
<p>13. SIGNATURE OF PHYSICIAN J. H. Smith</p>		<p>14. SIGNATURE OF REGISTRAR J. H. Smith</p>	
<p>15. SIGNATURE OF DECEASED (Blank)</p>		<p>16. SIGNATURE OF WITNESSES (Blank)</p>	
<p>17. SIGNATURE OF FUNERAL HOME (Blank)</p>		<p>18. SIGNATURE OF BURIAL PLACE (Blank)</p>	
<p>19. SIGNATURE OF COUNTY CLERK (Blank)</p>		<p>20. SIGNATURE OF CITY CLERK (Blank)</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5287

CERTIFICATE OF DEATH

Reg. Dist. No.

05252

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 3mos, 28das	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manakin		19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henrietta		4. DATE OF DEATH Month 5 Day 28 Year 19 58	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874?
9. AGE (In years last birthday) 84?		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Regressive C. V. A. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from January 30, 1958 to May 28, 1958 , that I last saw the deceased alive on May 28, 1958 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 5/28/58			
ACTUAL SIGNATURE Ludwig Benedict M.D.		PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/1/58	
22c. NAME OF CEMETERY OR CREMATORY CHARLES WESLEY		22d. LOCATION (City, town, or county) (State) MANOKIN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
ADDRESS Crownsville, Md.		24b. REGISTRAR'S SIGNATURE W. L. Leach	

CERTIFICATE OF DEATH

1927

REG. DIST. NO.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF PHYSICIAN</p> <p>11. SIGNATURE OF REGISTRAR</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF CORONER</p> <p>14. SIGNATURE OF JURY</p> <p>15. SIGNATURE OF JUDGE</p> <p>16. SIGNATURE OF CLERK</p> <p>17. SIGNATURE OF SHERIFF</p> <p>18. SIGNATURE OF DEPUTY SHERIFF</p> <p>19. SIGNATURE OF CONSTABLE</p> <p>20. SIGNATURE OF DEPUTY CONSTABLE</p> <p>21. SIGNATURE OF TOWNSHIP CLERK</p> <p>22. SIGNATURE OF COUNTY CLERK</p> <p>23. SIGNATURE OF STATE CLERK</p> <p>24. SIGNATURE OF SECRETARY</p> <p>25. SIGNATURE OF ASSISTANT SECRETARY</p> <p>26. SIGNATURE OF CHIEF CLERK</p> <p>27. SIGNATURE OF CHIEF DEPUTY CLERK</p> <p>28. SIGNATURE OF CHIEF TYPING CLERK</p> <p>29. SIGNATURE OF CHIEF BOOK-BINDER</p> <p>30. SIGNATURE OF CHIEF RECEPTION CLERK</p> <p>31. SIGNATURE OF CHIEF MAIL CLERK</p> <p>32. SIGNATURE OF CHIEF TELEPHONE CLERK</p> <p>33. SIGNATURE OF CHIEF RECORDS CLERK</p> <p>34. SIGNATURE OF CHIEF STATISTICS CLERK</p> <p>35. SIGNATURE OF CHIEF INVESTIGATION CLERK</p> <p>36. SIGNATURE OF CHIEF LABORATORY CLERK</p> <p>37. SIGNATURE OF CHIEF PHARMACY CLERK</p> <p>38. SIGNATURE OF CHIEF DISPENSARY CLERK</p> <p>39. SIGNATURE OF CHIEF MEDICAL CLERK</p> <p>40. SIGNATURE OF CHIEF NURSING CLERK</p> <p>41. SIGNATURE OF CHIEF DENTAL CLERK</p> <p>42. SIGNATURE OF CHIEF OPTICIAN CLERK</p> <p>43. SIGNATURE OF CHIEF BARBER CLERK</p> <p>44. SIGNATURE OF CHIEF COIFFEUR CLERK</p> <p>45. SIGNATURE OF CHIEF TAILOR CLERK</p> <p>46. SIGNATURE OF CHIEF HAT-MAKER CLERK</p> <p>47. SIGNATURE OF CHIEF SHOE-MAKER CLERK</p> <p>48. SIGNATURE OF CHIEF JEWELRY CLERK</p> <p>49. SIGNATURE OF CHIEF FUR-TRADER CLERK</p> <p>50. SIGNATURE OF CHIEF GUN-STORE CLERK</p> <p>51. SIGNATURE OF CHIEF SPORTS-STORE CLERK</p> <p>52. SIGNATURE OF CHIEF BOOK-STORE CLERK</p> <p>53. SIGNATURE OF CHIEF MUSIC-STORE CLERK</p> <p>54. SIGNATURE OF CHIEF ART-STORE CLERK</p> <p>55. SIGNATURE OF CHIEF PAINT-STORE CLERK</p> <p>56. SIGNATURE OF CHIEF FURNITURE-STORE CLERK</p> <p>57. SIGNATURE OF CHIEF CLOTHING-STORE CLERK</p> <p>58. SIGNATURE OF CHIEF GROCERY-STORE CLERK</p> <p>59. SIGNATURE OF CHIEF MEAT-STORE CLERK</p> <p>60. SIGNATURE OF CHIEF BAKERY-STORE CLERK</p> <p>61. SIGNATURE OF CHIEF BUTCHERY-STORE CLERK</p> <p>62. SIGNATURE OF CHIEF FISH-STORE CLERK</p> <p>63. SIGNATURE OF CHIEF VEGETABLE-STORE CLERK</p> <p>64. SIGNATURE OF CHIEF FLOWER-STORE CLERK</p> <p>65. SIGNATURE OF CHIEF SEED-STORE CLERK</p> <p>66. SIGNATURE OF CHIEF FARM-STORE CLERK</p> <p>67. SIGNATURE OF CHIEF TOOL-STORE CLERK</p> <p>68. SIGNATURE OF CHIEF HARDWARE-STORE CLERK</p> <p>69. SIGNATURE OF CHIEF ELECTRICAL-STORE CLERK</p> <p>70. SIGNATURE OF CHIEF PLUMBING-STORE CLERK</p> <p>71. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>72. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>73. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>74. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>75. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>76. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>77. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>78. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>79. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>80. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>81. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>82. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>83. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>84. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>85. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>86. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>87. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>88. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>89. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>90. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>91. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>92. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>93. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>94. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>95. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>96. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>97. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p> <p>98. SIGNATURE OF CHIEF CARPENTRY-STORE CLERK</p> <p>99. SIGNATURE OF CHIEF MASONRY-STORE CLERK</p> <p>100. SIGNATURE OF CHIEF PAINTING-STORE CLERK</p>	
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Wm. J. ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5288

CERTIFICATE OF DEATH

Reg. Dist. No.

05253

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gilbert				4. DATE OF DEATH Month 5 Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1905	
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 026X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CNS Syphilis DUE TO (c) Meningo-Encephalitic Type							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville				20g. (County) Prince Georges			
21. I certify that I attended the deceased from 1/6/55 to 5/7/58 , that I last saw the deceased alive on 5/7/58 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Reissmann				ADDRESS (Street, city or town, state) Crownsville State Hospital, Maryland			
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.				DATE SIGNED 5/8/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 12 1958		22c. NAME OF CEMETERY OR CREMATORY Wesley Henry Cem.		22d. LOCATION (City, town, or county) Bethesda	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Bellows				24a. REC'D BY REGISTRAR med.			
ADDRESS Mullington Md.				24b. REGISTRAR'S SIGNATURE med.			
DATE MAY 13 '58							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05254

5256

Item 7 Film 229 6-2-58 et

1. PLACE OF DEATH a. COUNTY <i>A.A. County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>AA CO</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 ANN 2 POLIS -</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>H. A. Ben. Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>SARAH</i> Middle <i>Brown</i> Last <i>Brown</i>				4. DATE OF DEATH Month <i>5</i> Day <i>21</i> Year <i>1958</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 27 1932</i>	
9. AGE (in years last birthday) <i>25 yrs.</i>		IF UNDER 1 YEAR Months <i>6</i> Days <i>21</i>		IF UNDER 24 HRS. Hours <i>19</i> Min. <i>58</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Witchess</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Annapolis</i>			
11. BIRTHPLACE (State or foreign country) <i>W.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Robert Brown</i>				14. MOTHER'S MAIDEN NAME <i>Marvella Johnson Annapolis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO. <i>Marvella Johnson Annapolis</i>			
17. INFORMANT <i>Marvella Johnson Annapolis</i>				Address <i>Annapolis</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple INJURIES.</i> <i>825X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Auto accident</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>5:24</i> p. m. <i>18</i> 19 <i>58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State) <i>AA CO MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhardt</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 26/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Burial Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Johnson</i>				ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 28 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. J. J. J.</i>			

MEDICAL CERTIFICATION

63

1

02

2

AP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CLERK		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CORONER		22. SIGNATURE OF SHERIFF		23. SIGNATURE OF DEPUTY SHERIFF		24. SIGNATURE OF CONSTABLE		25. SIGNATURE OF JAILER	
26. SIGNATURE OF PRISONER		27. SIGNATURE OF PRISONER		28. SIGNATURE OF PRISONER		29. SIGNATURE OF PRISONER		30. SIGNATURE OF PRISONER	
31. SIGNATURE OF PRISONER		32. SIGNATURE OF PRISONER		33. SIGNATURE OF PRISONER		34. SIGNATURE OF PRISONER		35. SIGNATURE OF PRISONER	
36. SIGNATURE OF PRISONER		37. SIGNATURE OF PRISONER		38. SIGNATURE OF PRISONER		39. SIGNATURE OF PRISONER		40. SIGNATURE OF PRISONER	
41. SIGNATURE OF PRISONER		42. SIGNATURE OF PRISONER		43. SIGNATURE OF PRISONER		44. SIGNATURE OF PRISONER		45. SIGNATURE OF PRISONER	
46. SIGNATURE OF PRISONER		47. SIGNATURE OF PRISONER		48. SIGNATURE OF PRISONER		49. SIGNATURE OF PRISONER		50. SIGNATURE OF PRISONER	
51. SIGNATURE OF PRISONER		52. SIGNATURE OF PRISONER		53. SIGNATURE OF PRISONER		54. SIGNATURE OF PRISONER		55. SIGNATURE OF PRISONER	
56. SIGNATURE OF PRISONER		57. SIGNATURE OF PRISONER		58. SIGNATURE OF PRISONER		59. SIGNATURE OF PRISONER		60. SIGNATURE OF PRISONER	
61. SIGNATURE OF PRISONER		62. SIGNATURE OF PRISONER		63. SIGNATURE OF PRISONER		64. SIGNATURE OF PRISONER		65. SIGNATURE OF PRISONER	
66. SIGNATURE OF PRISONER		67. SIGNATURE OF PRISONER		68. SIGNATURE OF PRISONER		69. SIGNATURE OF PRISONER		70. SIGNATURE OF PRISONER	
71. SIGNATURE OF PRISONER		72. SIGNATURE OF PRISONER		73. SIGNATURE OF PRISONER		74. SIGNATURE OF PRISONER		75. SIGNATURE OF PRISONER	
76. SIGNATURE OF PRISONER		77. SIGNATURE OF PRISONER		78. SIGNATURE OF PRISONER		79. SIGNATURE OF PRISONER		80. SIGNATURE OF PRISONER	
81. SIGNATURE OF PRISONER		82. SIGNATURE OF PRISONER		83. SIGNATURE OF PRISONER		84. SIGNATURE OF PRISONER		85. SIGNATURE OF PRISONER	
86. SIGNATURE OF PRISONER		87. SIGNATURE OF PRISONER		88. SIGNATURE OF PRISONER		89. SIGNATURE OF PRISONER		90. SIGNATURE OF PRISONER	
91. SIGNATURE OF PRISONER		92. SIGNATURE OF PRISONER		93. SIGNATURE OF PRISONER		94. SIGNATURE OF PRISONER		95. SIGNATURE OF PRISONER	
96. SIGNATURE OF PRISONER		97. SIGNATURE OF PRISONER		98. SIGNATURE OF PRISONER		99. SIGNATURE OF PRISONER		100. SIGNATURE OF PRISONER	

RECEIVED
JAN 10 1918
BALTIMORE
MD

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5289

CERTIFICATE OF DEATH

Reg. Dist. No. 05255

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade				c. LENGTH OF STAY IN 1b Baltimore 3y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Army Hospital				d. STREET ADDRESS 4305 Groveland Ave			
3. NAME OF DECEASED (Type or print) First LILLIAN Middle Grove Last BUTEMENT				4. DATE OF DEATH Month May Day 6 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Dec 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edmund Adams				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address 4305 Groveland Ave, Balto, 15, MD Husband Ralston Butement.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 April 1958 , to 6 May 1958 , that I last saw the deceased alive on 5 May 1958 , and that death occurred at 800A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John G. Robertson M.D. USAH Ft George G Meade Md.				DATE SIGNED			
PHYSICIAN'S NAME (Type) JOHN G. ROBERTSON, Capt, MC, U.S. Army Hospital, Ft Meade, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. J. Tiekner & Sons - Balto 17 Md				24a. REC'D BY REGISTRAR DATE 6 May 58		24b. REGISTRAR'S SIGNATURE R.H. MCGILL, CWO, USA	

CERTIFICATE OF DEATH

NAME OF DECEASED James H. Brown		AGE 45		SEX Male		RACE White		DATE OF DEATH Jan 15, 1925		PLACE OF DEATH Home	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
BIRTH Jan 1, 1880		PLACE OF BIRTH Maryland		PARENTS John Brown, Mary Smith		SPOUSE Mary Brown		CHILDREN None		PREVIOUS ILLNESS None	
DATE OF BIRTH Jan 1, 1880		PLACE OF BIRTH Maryland		PARENTS John Brown, Mary Smith		SPOUSE Mary Brown		CHILDREN None		PREVIOUS ILLNESS None	
DATE OF DEATH Jan 15, 1925		PLACE OF DEATH Home		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A LICENSED PHYSICIAN OR A LICENSED NURSE.

STATE OF MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5290

CERTIFICATE OF DEATH

05257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6m. 23d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Whitehall 12x-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Tittle Last Chaney		4. DATE OF DEATH Month 5 Day 4 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/4/04
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4 Hours 19 Min. 58	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver T. Tittle		14. MOTHER'S MAIDEN NAME Carrie Gibson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Decubital Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Syphilitic Cirrhosis of the Liver 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 11, 1957 to May 4, 1958 , that I last saw the deceased alive on May 4, 1958 , and that death occurred at 11:55A M, from the causes and on the date stated above. ACTUAL SIGNATURE Ludwig Benedict M.D. ADDRESS (Street, city or town, state) Crownsville State Hospital, Maryland DATE SIGNED PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville State Hospital, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7-1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Joy		22d. LOCATION (City, town, or county) (State) Froyer Rd. Balto Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kurtz		24a. REC'D BY REGISTRAR DATE MAY 9 '58	
ADDRESS Jarrettsville		24b. REGISTRAR'S SIGNATURE W. Beach	

Theodore Roosevelt

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05258

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

5291

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN lb <u>5 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hazel S. Chapman/ Furnace Rd. Box 190</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hazel S. Chapman</u>			4. DATE OF DEATH Month Day Year <u>May the 11th. 19 58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/14</u>		9. AGE (In years last birthday) <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>224-09-0955</u>		17. INFORMANT <u>Mr. John A. Chapman (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>(City or town) (County) (State)</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/11/58</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home, 130 E. Fort Ave., Balto. 30</u>			ADDRESS		24a. REC'D BY REGISTRAR <u>MAY 14 '58</u>
					24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

tem 20 Film 230 6-9-58 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **05259**

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph W. CHEW.		4. DATE OF DEATH 5/4/1958	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1933
9. AGE (In years last birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired, give former occupation) Communication Lt. U.S. Army		11. BIRTHPLACE (State or foreign country) Wash. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Reginald Chew	
14. MOTHER'S MAIDEN NAME Mary Hillary		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) Yes	
16. SOCIAL SECURITY NO. XXXX-XX-XXXX		17. INFORMANT Mary Chew - Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Femur R - Fr. mandible 823X DUE TO Fracture Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Lacer DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto struck telephone pole	
20c. TIME OF INJURY Month, Day, Year 5-4-19 Hour 5-4 a.m. 5-4 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Annapolis		20f. (City or town) (County) (State) Annapolis A.A. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. L. N. H. H. H.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. L. N. H. H. H.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 5-8-58	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. H. H. H.		24a. REC'D BY REGISTRAR DATE MAY 6 '58	
		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

MEDICAL CERTIFICATION

or removal.

(5)

George Cromwell
Cromwell
1025 North St.

Joseph W. Male Col.

Communication to St. D. (Army) St. D. C.
Regimental Clerk
1025 North St.

Marshall C. C.
Cromwell
1025 North St.

8-11-1833
St. D. C. St. D. C.
Marshall C. C.
Cromwell

Marshall C. C. Cromwell
8-11-1833
St. D. C. St. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5292

CERTIFICATE OF DEATH

Reg. Dist. No.

05260

1. PLACE OF DEATH a. COUNTY <u>B. & A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. & A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Loggin Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Clark</u> Middle <u>Clark</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-163148</u>	
17. INFORMANT <u>George Clark</u> Address <u>1803 Robin Smoell Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X cerebral vascular accident</u> DUE TO (b) <u>hypertensive C.V. disease</u> DUE TO (c) <u>gen. arterio sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 4th</u> , 19 <u>58</u> , to <u>5-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-14</u> , 19 <u>58</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Bodler</u> M.D. <u>45 Franklin St. Annapolis Md</u>		DATE SIGNED <u>5-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Edith Bodler M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Reese #108 Wash St. Annapolis</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A low this certificate has been signed by the attending physician and completely filled in by the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5293

Items 9.1311, film 6229 6-1-58 et

CERTIFICATE OF DEATH

05262

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
				d. STREET ADDRESS 838 E. Preston Street			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle T Last COLLIER		4. DATE OF DEATH Month May Day 25 Year 1958					
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Jan 1886	9. AGE (In years last birthday) 72 7/8 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired M/Sgt		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1915-1915		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Marked pulmonary congestion and edema with DUE TO areas of bronchopneumonia, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration and Acidosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 May , 19 58 , to 25 May , 19 58 that I last saw the deceased alive on _____, 19 _____, and that death occurred at 0612 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Army Hospital, Ft Meade, Md DATE SIGNED 26 May 58							
ACTUAL SIGNATURE Dee J. Mc Gonigle				PHYSICIAN'S NAME (Type) DEE J. MC GONIGLE, CAPT, MC, U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28 1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Gila Wiedefeld				ADDRESS 900 E Biddle St		24a. REC'D BY REGISTRAR DATE MAY 28 58	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5294

CERTIFICATE OF DEATH

Reg. Dist. No.

05263

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1yr. 9m. 22d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 323 Popleton Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alice Cottrell Commodore			4. DATE OF DEATH Month 5 Day 9 Year 19 58		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/ /1881		9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Horse Cottrell			14. MOTHER'S MAIDEN NAME Nancy Ann		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT Hospital Records Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from 7/17 , 19 56 , to 5/9 , 19 58 , that I last saw the deceased alive on 5/9 , 19 58 , and that death occurred at 3:25 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 5/12/58 ACTUAL SIGNATURE Ludwig Benedict M.D. PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D. Crownsville State Hospital, Md. 5/12/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE-THEREOF 5/12/58		22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School	
22d. LOCATION (City, town, or county) Baltimore, Md. (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 Wash. St. Annap. Md. ADDRESS _____		24a. RECEIVED BY REGISTRAR MAY 15 '58		24b. REGISTRAR'S SIGNATURE Wm. Reese	

• **Topic:**

5295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a. a. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Orlando</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville (RURAL) ANNAH'S</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pine Castle</u>		48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANNS Nursing Home</u>		d. STREET ADDRESS <u>CECIL RD., MILLERSVILLE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>COOK</u> Last <u>COOK</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17th</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 7th - 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>9</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Cook</u>		14. MOTHER'S MAIDEN NAME <u>Eichelberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-7339</u>	
17. INFORMANT <u>Monnie Edien, Crownsville-Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostate Carcinoma -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>177X</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>May</u> Day <u>19</u> Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Orlando</u> (County) <u>Orange</u> (State) <u>FL</u>	
21. I certify that I attended the deceased from <u>4-29-58</u> to <u>5-17-58</u> , that I last saw the deceased alive on <u>5-17-58</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Orlando, Fla.</u> DATE SIGNED <u>Dr. Joseph Lipsky</u>	
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKY</u>		PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 21, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Livingston</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>	DATE OF BIRTH <i>Jan 15 1900</i>	PLACE OF BIRTH <i>New York City</i>
RESIDENCE <i>123 Main St, New York City</i>		OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>		
DATE OF DEATH <i>Dec 10 1945</i>		PLACE OF DEATH <i>Home</i>		MANNER OF DEATH <i>Natural</i>		
SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		
DATE OF SIGNATURE <i>Dec 10 1945</i>		DATE OF SIGNATURE <i>Dec 10 1945</i>		DATE OF SIGNATURE <i>Dec 10 1945</i>		



RECEIVED
NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DEC 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05265
Reg. Dist. No.

5296

Items 7, 11, 12 Film G229 6-3-58 et

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deale Beach c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First BETTY Middle EVA Last CRAWFORD		4. DATE OF DEATH Month May Day 14 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/16
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) New Britain, Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm Markovich	
14. MOTHER'S MAIDEN NAME Eva Karclak		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no.	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive decomposition of body 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Presumed drowning DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found lying face down on beach 8' from water (Deale Beach)	
20c. TIME OF INJURY Month, Day, Year Found 5:50 p.m. 5/21 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water	20f. (City or town) (County) (State) Anne Arundel Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE R S Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/22/58	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 5/24/58	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) New Britain Conn.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Ulbrich, Balt. Md.		24. REC'D BY REGISTRAR 26 58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Ulbrich	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05256

5257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General Hosp.</i>		d. STREET ADDRESS <i>1705 Melvin Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Virginia Lauther Carruck</i>		4. DATE OF DEATH Month <i>5</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-26-1869</i>
9. AGE (In years last birthday) <i>89</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Lusby Lauther</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr Amos L. Lorens</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Enterovascular Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTESTINAL HEMORRHOID</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/22</i> , 1958, to <i>5/24</i> , 1958, that I last saw the deceased alive on <i>5/24</i> , 1958, and that death occurred at <i>10:37</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Edward J. Beck</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-27-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Layton Sins</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Orin Smith</i>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DECEASED'S NAME <i>John William Smith</i>		SEX Male	
DATE OF BIRTH Jan 15 1900		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		MARITAL STATUS Married	
DATE OF DEATH Jan 20 1950		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:30 AM		CAUSE OF DEATH Coronary Thrombosis	
MEDICAL HISTORY Hypertension, Atherosclerosis		PRESENT ILLNESS Chest pain, shortness of breath	
PHYSICIAN'S SIGNATURE <i>Dr. J. H. Jones</i>		COUNTY CLERK'S SIGNATURE <i>John Doe</i>	
CITY CLERK'S SIGNATURE <i>John Doe</i>		STATE CLERK'S SIGNATURE <i>John Doe</i>	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy thereof to be furnished to the family of the deceased.

1 7 M 00 I 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

5259

CERTIFICATE OF DEATH

Reg. Dist. No.

05261

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 30 Cornhill				d. STREET ADDRESS 30 Cornhill			
3. NAME OF DECEASED (Type or print) Archibald				4. DATE OF DEATH Month 5 Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Anne Arundel Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Coates			14. MOTHER'S MAIDEN NAME Mary Matthews				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-12-9498		17. INFORMANT Claudella Coates--30 Cornhill Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis grade III DUE TO (c) 3 months						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from May 9th, 1958 , to May 16, 1958 , that I last saw the deceased alive on 5-16 , 19 58 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R.L. Richardson		M.D. 110-CLAY ST ANNAPOLIS MD 5/19/58		ADDRESS (Street, city or town, state) 110 CLAY Street-Annapolis, Md.			
PHYSICIAN'S NAME (Type) R.L. Richardson		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-58		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Annapolis-Md.		24a. REC'D BY REGISTRAR DATE MAY 21 '58	
				24b. REGISTRAR'S SIGNATURE Charles E. Hicks III			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

May 17, 1994

CERTIFICATE OF DEATH

Reg. Dist. No. 05266

5260

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last DAISY MALVINA CRUTCHLEY				4. DATE OF DEATH Month Day Year MAY 30 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1891		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vinton Thomas				14. MOTHER'S MAIDEN NAME Daisy Basil			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mr. Robert Crutchley-Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerulonephritis DUE TO (c) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio insufficiency							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1953, to May 30 , 1958, that I last saw the deceased alive on May 30 , 1958, and that death occurred at 12:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral DATE SIGNED 5/30/58							
ACTUAL SIGNATURE John C. Hedeman M.D.				PHYSICIAN'S NAME (Type) John Hedeman MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME ADDRESS ANNAPOLIS, MARYLAND				24a. REC'D BY REGISTRAR DATE JUN 3 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARI AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to determine what consumers want and what problems they are facing. Once a need is identified, the next step is to develop a concept that addresses the need. This concept should be unique, valuable, and feasible. The third step is to create a prototype of the product. This allows the creator to test the concept and make any necessary adjustments. The fourth step is to conduct a business plan. This involves determining the costs of production, the pricing strategy, and the marketing plan. Finally, the product is launched into the market. The creator should monitor sales and customer feedback to ensure the product is successful and make any necessary adjustments.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5297

CERTIFICATE OF DEATH

Reg. Dist. No.

05267

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. LENGTH OF STAY IN 1b <u>29 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Race Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Deel</u>		4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McNamee of Lanston</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George F. Deel</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mullins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>420-05-4440</u>	
17. INFORMANT <u>Mrs. Evelyn Leishure</u>		Address <u>Laurel, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Sclerosis</u> DUE TO (d) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>45 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>58</u> , to <u>1958</u> , that I last saw the deceased alive on <u>May 12</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u>		ADDRESS (Street, city or town, state) <u>Laurel, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>		DATE SIGNED <u>May 12, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 15, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Jessup Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Chandler</u>		ADDRESS <u>Laurel, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 16 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. C. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John J. O'Connell</i>		AGE <i>45</i>		SEX <i>M</i>	
DATE OF DEATH <i>Aug 12 1902</i>		PLACE OF DEATH <i>At home</i>		CAUSE OF DEATH <i>Heart disease</i>	
RESIDENCE <i>123 Main St. Boston</i>		OCCUPATION <i>Engineer</i>		MANNER OF DEATH <i>Natural</i>	
DATE OF BIRTH <i>Aug 12 1857</i>		PLACE OF BIRTH <i>Ireland</i>		EDUCATION <i>High School</i>	
MARRIAGE <i>Married</i>		SPOUSE <i>Elizabeth O'Connell</i>		CHILDREN <i>3</i>	
PREVIOUS ILLNESS <i>None</i>		MEDICAL ATTENDANCE <i>Dr. J. J. O'Connell</i>		BURIAL <i>St. Patrick's Church</i>	
SIGNATURE OF DECEASED <i>John J. O'Connell</i>		SIGNATURE OF WITNESS <i>Elizabeth O'Connell</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. J. O'Connell</i>	
DATE OF SIGNATURE <i>Aug 12 1902</i>		DATE OF SIGNATURE <i>Aug 12 1902</i>		DATE OF SIGNATURE <i>Aug 12 1902</i>	

MADE IN U.S.A.
PATENTED
JULY 1901

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 229 5-23-58 ams										
5298										
CERTIFICATE OF DEATH										
Reg. Dist. No 27										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade					c. LENGTH OF STAY IN 1b 1 yr 7 mo					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Dundalk) 0353.2					
					d. STREET ADDRESS 1925 Rettman Lane					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) GEORGE					4. DATE OF DEATH Month MAY Day 6 Year 19 58					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 May 1905		9. AGE (In years last birthday) 52 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME deceased - unknown					14. MOTHER'S MAIDEN NAME deceased - unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-38-8553		17. INFORMANT Address Records - Fort George G Meade, Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Postoperative hemorrhage										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Endobronchial biopsy										
(c) Anaplastic carcinoma of the right upper lobe										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hrs.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 19 Month, Day, Year p. m.					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 May , 19 58 , to 6 May , 19 58 , that I last saw the deceased alive on 6 May , 19 58 , and that death occurred at 1345 PM , from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) DATE SIGNED										
ACTUAL SIGNATURE Gene D Trettin M.D. U. S. ARMY HOSP, FT MEADE, MD 6 May 58										
PHYSICIAN'S NAME (Type) GENE D. TRETTIN, MD, U. S. ARMY HOSPITAL, FT GEORGE G. MEADE, MARYLAND										
22a. DATE OF REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)				
Removal		5/9/58		Edwards Funeral Home		Dobbs Ferry New York				
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Woberton Funeral Home, Inc.					24a. REC'D BY REGISTRAR DATE 7 May 58		24b. REGISTRAR'S SIGNATURE CLAUDE D. LAUSTER, CWO			
6306 - Belair Rd - Baltimore - 6, Md.										

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MEDICAL CERTIFICATION

5299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 1yr, 11mo, 25d.	
d. STREET ADDRESS Laura Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilbert Dickerson		4. DATE OF DEATH Month 5 Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Dickerson		14. MOTHER'S MAIDEN NAME Margie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-26-7710	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, far advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with infectious disease and mal-		INTERVAL BETWEEN ONSET AND DEATH Known to us since admission	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) nutrition	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9 , 19 56 , to May 4 , 19 58 , that I last saw the deceased alive on May 4 , 19 58 , and that death occurred at 1:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 5/5/58			
ACTUAL SIGNATURE Lionel McHenry Mapp M.D.		PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-7-58	
22c. NAME OF CEMETERY OR CREMATORY C. Fred. Ward School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reesett		24a. REC'D BY REGISTRAR May 9 58	
ADDRESS 108 Wash. St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)
1SM 10/57

68

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05270

Item 9, Film G229, 5/26/58, fcy

5261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived): If institution: Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>45 C. Ck. Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Diggs</u> Last <u>Diggs</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-15-1874</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Brewery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Owens</u>		14. MOTHER'S MAIDEN NAME <u>Annie Owens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>James Santt - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) <u>104rs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>80 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1950</u> to <u>5-12, 1958</u> , that I last saw the deceased alive on <u>5-12, 1958</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annap Md</u> DATE SIGNED <u>5-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		<u>62 Cathedral St Annapolis Md 5-13-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr. - Annap, Md.</u>		ADDRESS <u>62 Cathedral St Annapolis Md 5-13-58</u>	
24a. REC'D BY REGISTRAR <u>MAY 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Geese</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School Children's Center, Laurel, Md.				d. STREET ADDRESS 302 C Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Dozier, Jr. Last				4. DATE OF DEATH Month May Day 4 Year 19 58			
5. SEX male		6. COLOR OR RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/16/57	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Dozier Sr.				14. MOTHER'S MAIDEN NAME Leedora Moss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Social Service, Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) -- DUE TO (c) -- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -- INTERVAL BETWEEN ONSET AND DEATH from birth							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4/57 , 19___, to 5/4/58 , 19___, that I last saw the deceased alive on 5/4/58 , 19___, and that death occurred at 1:18p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James E. Boyland M.D. Children's Center, Laurel, Md. PHYSICIAN'S NAME (Type) James E. Boyland, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-6-58		22c. NAME OF CEMETERY OR CREMATORY DTS Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. James Jr				ADDRESS D.T.S. Laurel Md		24a. REC'D BY REGISTRAR DATE MAY 8 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5301

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stumbrills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1916 Spa Road</u>	
3. NAME OF DECEASED (Type or print) <u>Myrtle Gladys Ennis</u>		4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1932</u>
9. AGE (In years last birthday) <u>25</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stressess</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Little Campus Inn</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Ennis Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-28-4458</u>	
17. INFORMANT <u>Sylvia Ennis</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>PM</u> m. <u>5/21/58</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Annapolis</u> (County) <u>St. Anne</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>5/21/58</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Green</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Green</u>	

FOR FILING
HEALTH DEPT.

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

RECEIVED
JAN 15 1918

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPT.

NAME

RESIDENCE

DATE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF ASSISTANT

5262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parole AA Co MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA General Hospital</u>				d. STREET ADDRESS <u>Shady Oakes</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>P.</u> Last <u>Faudree</u>				4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12th 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Hardy Man AA Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Luther Faudree</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Lula A. Faudree Parole AA Co MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.2</u> <u>superior mesenteric artery thrombosis</u> DUE TO (b) <u>early peritonitis</u> DUE TO (c) <u>with infarction of most of small and large bowel</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>paralytic ileus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>52</u> , to <u>5-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-2</u> , 19 <u>58</u> , and that death occurred at <u>1:40</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edith Rodler M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>45 FRANKLIN ST. ANNAPOLIS Maryland</u>			
DATE SIGNED <u>5-2-58</u>							
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF <u>5-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5263

CERTIFICATE OF DEATH

05274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>35 Jefferson Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Myra Henrietta Frank</u>		4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ernest C. Gauss</u>	
14. MOTHER'S MAIDEN NAME <u>Alvaretta Green</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Reginal Chambers #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerosis, Cerebral</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>55</u> , to <u>16 MAY</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>16 MAY</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis Md</u> DATE SIGNED <u>May 20 1958</u>			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor & Sons</u> ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 20 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. S. Search</u>

CERTIFICATE OF DEATH

5283

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		35		11-1-27		MOBILE, ALABAMA		LABORER		MARRIED		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF WITNESS		16. SIGNATURE OF REGISTRAR	
11-5-68		11:00 PM		HOME		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. FILING DATE		22. FILING TIME		23. FILING PLACE		24. FILING OFFICE	
BALTIMORE		BALTIMORE		MD		21201		11-5-68		11:00 PM		BALTIMORE		BALTIMORE	

5302

CERTIFICATE OF DEATH

05275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. LENGTH OF STAY IN 1b <u>7 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANNS NURSING Home</u>				e. STREET ADDRESS <u>104 BALTIMORE, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM ERNEST FREEZE</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1883</u>	9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD Dispatcher</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		12c. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>George Freeze</u>				14. MOTHER'S MAIDEN NAME <u>Marriet Gough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>JEAN WILLIAMS</u> Address <u>MILLERSVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>1 year</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>4-14-58</u> to <u>5-19-58</u> , that I last saw the deceased alive on <u>4-17-58</u> , and that death occurred <u>12:15 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Kipskey</u>				DATE SIGNED <u>May 26 1958</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH KIPSEY</u>				ADDRESS <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 22, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKLEY</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or attending physician. After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF BIRTH <i>Jan 15 1910</i></p>		<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. DATE OF DEATH <i>Jan 20 1955</i></p>		<p>8. PLACE OF DEATH <i>Home</i></p>		<p>9. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>10. MEDICAL HISTORY <i>None</i></p>		<p>11. PRESENT ILLNESS <i>None</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5303

CERTIFICATE OF DEATH

Reg. Dist. No. 05276

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie, (Glen Gardens)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>503 Kent Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Cross Gardner</u>				4. DATE OF DEATH Month Day Year <u>May 4 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 7-1895</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Barrows Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Serern, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George T. Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Minerva Disney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-14-5255</u>			
17. INFORMANT <u>Mrs. Dorothy Hayes</u>				Address <u>Same as no 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>3 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct</u> , 1946, to <u>May 4</u> , 1958, that I last saw the deceased alive on <u>April 15</u> , 1958, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward G. Merritt</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6240 Mills Rd</u> <u>5-4-58</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May-7-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 8 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5304

Item 1 Film G229 5-19-58 et
CERTIFICATE OF DEATH

Reg. Dist. No.

05277

1. PLACE OF DEATH a. COUNTY A. A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Pasadena) Pinehurst on the Bay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle A. Last GOSNELL		4. DATE OF DEATH Month May Day 11 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Train Dispatcher		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME - Rufus Gosnell		14. MOTHER'S MAIDEN NAME Hannah Burton -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jeanette B. Gosnell - Pasadena, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular DUE TO (c) disease with coronary insufficiency INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized osteoarthritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1958 to May 11, 1958 , that I last saw the deceased alive on May 11, 1958 , and that death occurred at 10:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. McLaughlin		M.D. Pasadena, Maryland DATE SIGNED May 11, 1958	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/58	
22c. NAME OF CEMETERY OR CREMATORY Louder Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto		24. REC'D BY REGISTRAR MAY 13 '58	
25. REGISTRAR'S SIGNATURE W. J. Dickner			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1150 EASTPORT TERRACE				e. STREET ADDRESS 1150 EASTPORT TERRACE			
3. NAME OF DECEASED (Type or print) First Middle Last JACKSON HALL				4. DATE OF DEATH Month Day Year MAY 9 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 9 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN				10b. KIND OF BUSINESS OR INDUSTRY FISH + OYSTERS		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE M. HALL				14. MOTHER'S MAIDEN NAME SALLIE GRISCOMB			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Earl J. Hall Address (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) — (c) —							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED MAY 9/58			
EXAMINER'S NAME (Type) E. LINHARDT		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF MAY 12 1958	22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.	22d. LOCATION (City, town, or county) (State) ANNAPOLIS MARYLAND				
23. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR-SONS		ADDRESS ANNAPOLIS MARYLAND		24a. REC'D BY REGISTRAR MAY 12 '58	24b. REGISTRAR'S SIGNATURE Alfred		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED GEORGE M. HILL		AGE 42	SEX M	RACE W
RESIDENCE 1212 N. E. ST. BALTIMORE, MD.		DATE OF DEATH MAY 1972		
PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		
MANNER OF DEATH NATURAL		MEDICAL HISTORY NO PREVIOUS ILLNESS		
OCCUPATION CLERK		EDUCATION HIGH SCHOOL		
MARRIAGE MARRIED		SINGLE		
CHILDREN ONE		OTHERS NO		
SIGNATURE OF EXAMINER [Signature]		DATE MAY 1972		
OFFICIAL SEAL		FEE PAID		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5305

CERTIFICATE OF DEATH

Reg. Dist. No.

05279

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PT. Pleasant				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PT. Pleasant			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PT. Pleasant Beach				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle H Last Nannyman		4. DATE OF DEATH Month 5 Day 22 Year 19 58		5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 4-1901		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Sherman				14. MOTHER'S MAIDEN NAME Ossie Townsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases all through G. & I. tract DUE TO (c) 7 months							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/2/57 , 19 57 , to 5/32 , 19 58 , that I last saw the deceased alive on 5/32/58 , 19 58 , and that death occurred at 11 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gustave H. Faubert				ADDRESS (Street, city or town, state) 5-7150 S. E. St. Louis Ave. MD.			
PHYSICIAN'S NAME (Type) GUSTAVE H. FAUBERT-M.D.				DATE SIGNED 7/23/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 5-26-58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven An.		22d. LOCATION (City, town, or county) (State) Alen Bunde, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mc Culley Funeral Home				ADDRESS 130 E Fort Ave.		24a. REC'D BY REGISTRAR DATE MAY 26 '58	
				24b. REGISTRAR'S SIGNATURE Alen Bunde			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05280
Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL or nearest town) <u>Altona Beach, Glen Burnie</u>		c. LENGTH OF STAY in 1b <u>1 1/2 hour.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Big Burley Cove, off Stoney Creek</u>		d. STREET ADDRESS <u>910 Potapso Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Ronald Michael Haslego</u>		4. DATE OF DEATH May 18th. 19 58	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/41</u>
9. AGE (in years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Hazleton, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Michael Haslego</u>		14. MOTHER'S MAIDEN NAME <u>Celia Kilusky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Michael Haslego, (father)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental drowning.</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Was swimming in 15 feet of water and suddenly went under the water.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5/18/58 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Big Burley Cove</u>		20f. (City or town) (County) (State) <u>Altona Beach, Glen Burnie, A.A.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>5/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Homes - 130 E. Fort Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



1. NAME OF DECEASED: [REDACTED]

2. SEX: [REDACTED]

3. AGE: [REDACTED]

4. DATE OF BIRTH: [REDACTED]

5. PLACE OF BIRTH: [REDACTED]

6. OCCUPATION: [REDACTED]

7. MARITAL STATUS: [REDACTED]

8. CAUSE OF DEATH: [REDACTED]

9. MANNER OF DEATH: [REDACTED]

10. SIGNATURE OF EXAMINER: [REDACTED]

11. DATE OF EXAMINATION: [REDACTED]

12. PLACE OF EXAMINATION: [REDACTED]

13. SIGNATURE OF WITNESS: [REDACTED]

14. DATE OF SIGNATURE: [REDACTED]

15. PLACE OF SIGNATURE: [REDACTED]

ATTEST: [REDACTED]

NOTARY PUBLIC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>HH</u> STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brown Woods Rd. 4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brown Woods</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 4 Box 28</u>	
3. NAME OF DECEASED (Type or print) <u>VIOLA EVELYN HENSON</u>		4. DATE OF DEATH <u>MAY 18 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Ch</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
13. FATHER'S NAME <u>Dennis Harold</u>		14. MOTHER'S MAIDEN NAME <u>Lara Stansbury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-30-5251</u>	
17. INFORMANT <u>Margaret Henson</u>		Address <u>Brown Woods Rd. 4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Cervix</u> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 18, 1957</u> to <u>May 18, 1958</u> , that I last saw the deceased alive on <u>May 18, 1958</u> , and that death occurred at <u>8:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>MAY 23 1958</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5-21-1958</u>	<u>Broadneck</u>	<u>Shidmore a.a.co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Reese</u>		24a. REC'D BY REGISTRAR <u>MAY 23 1958</u>	
ADDRESS <u>108 Wash. St. Anna, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

FILE NO.

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

5265

CERTIFICATE OF DEATH

05282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1963 West St.</i>		d. STREET ADDRESS <i>1963 West Street.</i>	
3. NAME OF DECEASED (Type or print) <i>Lovelace</i> First <i>C.</i> Middle <i>Herndon</i> Last		4. DATE OF DEATH Month <i>5</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-28-1874</i> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>84</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Chapella Gouch</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James Herndon</i>		Address <i>1963 West St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <i>434.1</i> IMMEDIATE CAUSE (a) <i>Congestive Cardiac Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-12-57</i> 19, to <i>5-21-58</i> 19, that I last saw the deceased alive on <i>5-20-58</i> 19, and that death occurred at <i>1:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		DATE SIGNED <i>5-23-58</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>5-25-58</i>	<i>Brewer Hall</i>	<i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Reese</i>		ADDRESS <i>108 Wash St. Annapolis Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>MAY 26 58</i>		<i>W. Reese</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK
BOND

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of mortuary		17. Signature of funeral home		18. Signature of cemetery	
19. Signature of mortuary		20. Signature of funeral home		21. Signature of cemetery	
22. Signature of mortuary		23. Signature of funeral home		24. Signature of cemetery	
25. Signature of mortuary		26. Signature of funeral home		27. Signature of cemetery	
28. Signature of mortuary		29. Signature of funeral home		30. Signature of cemetery	
31. Signature of mortuary		32. Signature of funeral home		33. Signature of cemetery	
34. Signature of mortuary		35. Signature of funeral home		36. Signature of cemetery	
37. Signature of mortuary		38. Signature of funeral home		39. Signature of cemetery	
40. Signature of mortuary		41. Signature of funeral home		42. Signature of cemetery	
43. Signature of mortuary		44. Signature of funeral home		45. Signature of cemetery	
46. Signature of mortuary		47. Signature of funeral home		48. Signature of cemetery	
49. Signature of mortuary		50. Signature of funeral home		51. Signature of cemetery	
52. Signature of mortuary		53. Signature of funeral home		54. Signature of cemetery	
55. Signature of mortuary		56. Signature of funeral home		57. Signature of cemetery	
58. Signature of mortuary		59. Signature of funeral home		60. Signature of cemetery	
61. Signature of mortuary		62. Signature of funeral home		63. Signature of cemetery	
64. Signature of mortuary		65. Signature of funeral home		66. Signature of cemetery	
67. Signature of mortuary		68. Signature of funeral home		69. Signature of cemetery	
70. Signature of mortuary		71. Signature of funeral home		72. Signature of cemetery	
73. Signature of mortuary		74. Signature of funeral home		75. Signature of cemetery	
76. Signature of mortuary		77. Signature of funeral home		78. Signature of cemetery	
79. Signature of mortuary		80. Signature of funeral home		81. Signature of cemetery	
82. Signature of mortuary		83. Signature of funeral home		84. Signature of cemetery	
85. Signature of mortuary		86. Signature of funeral home		87. Signature of cemetery	
88. Signature of mortuary		89. Signature of funeral home		90. Signature of cemetery	
91. Signature of mortuary		92. Signature of funeral home		93. Signature of cemetery	
94. Signature of mortuary		95. Signature of funeral home		96. Signature of cemetery	
97. Signature of mortuary		98. Signature of funeral home		99. Signature of cemetery	
100. Signature of mortuary		101. Signature of funeral home		102. Signature of cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A A General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frederick James Holland</i>		4. DATE OF DEATH Month Day Year <i>5- 5 19 58</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 20-1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. FUND 1 YEAR Months Days	11. FUND 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City Employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Foreman</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James Holland</i>		14. MOTHER'S MAIDEN NAME <i>Laura Collins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT Address <i>Mrs Nicholas Bottner</i>		(2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cpt. Prolegary Skene</i> <i>812X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Leukemia Fibula Rt.</i> DUE TO (c) <i>Leukemia</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Struck by auto</i>	
20c. TIME OF INJURY Month, Day, Year <i>PM 5/5 1958</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Annapolis Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. Wharft</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. Wharft</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Normal</i>		22b. DATE THEREOF <i>5-8-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor</i>		24a. REC'D BY REGISTRAR <i>West</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>West</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial. Page 4 should be used as a removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05284

5308

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 yr. 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 35 Dean Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nicholas Hopkins		4. DATE OF DEATH Month 5 Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/04
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Hopkins		14. MOTHER'S MAIDEN NAME Celia Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 023x DUE TO Congestive Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syphilitic Cardiovascular Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 5/8 , 19 57 to 5/20/58 , 19____, that I last saw the deceased alive on 5/20/58 , 19 58 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. M.D. Crownsville State Hospital, Md. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-24-1958	
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE MAY 23 '58		24b. REGISTRAR'S SIGNATURE Overman	

5309

CERTIFICATE OF DEATH

Reg. Dist. No.

05285

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holly Hill Harbor, Edgewater				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Box 216-B, Holly Hill Harbor				e. STREET ADDRESS Rt. 1, Box 216 B			
3. NAME OF DECEASED (Type or print) First Raymond Edward Middle Huntt Last Huntt				4. DATE OF DEATH Month May Day 3 Year 1958			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1894	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain of Fire Dept.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward Lee Huntt			
14. MOTHER'S MAIDEN NAME Rosa Foust				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Annie Huntt (Wife) Address Rt. 1, Box 216B Edgewater, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease DUE TO (c) 1 1/2 year						INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/4 , 19 57 , to 5/3 , 19 58 , that I last saw the deceased alive on May 3rd , 19 58 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rt. 1, Box 277-M Edgewater, Maryland DATE SIGNED 5/3/58							
ACTUAL SIGNATURE Sylvia M. Lim M.D.				PHYSICIAN'S NAME (Type) SYLVIA M. LIM, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 6-58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661-Jd Hope Rd & E				24a. REC'D BY REGISTRAR MAY 6 '58		24b. REGISTRAR'S SIGNATURE Allen	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5328

Form 100-100

NAME OF DECEASED HOLLY WILLIAM		AGE 25	
SEX Male		RACE White	
DATE OF BIRTH 1913		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Student		EDUCATION High School	
MARRIAGE Never Married		RELIGION Roman Catholic	
DATE OF DEATH 1938		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DISEASE OR INJURY Coronary Artery Disease		IMMEDIATE CAUSE Myocardial Infarction	
PERIOD OF ILLNESS Several Months		ONSET OF ILLNESS Late 1937	
TREATMENT Medical		HOSPITAL St. Joseph's Hospital	
DATE OF EXAMINATION 1938		PLACE OF EXAMINATION Baltimore, Md.	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF REGISTRAR J. H. Smith	
DATE OF SIGNATURE 1938		PLACE OF SIGNATURE Baltimore, Md.	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7 & 9, Film G231, 7/11/58

CERTIFICATE OF DEATH

Reg. Dist. No.

06428

5310

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		e. STREET ADDRESS <u>308 PULASKI STREET</u>	
3. NAME OF DECEASED (Type or print) <u>JOHNSON STANLEY</u>		4. DATE OF DEATH <u>MAY 30 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>CROWNSVILLE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> <u>151x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO WITH <u>Metastases to the Liver</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Syphilis, Generalized and Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/18 1957</u> to <u>5/30 1958</u> , that I last saw the deceased alive on <u>5/29 1958</u> and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard W. Henry Mapp</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>5-30-58</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		<u>Crownsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-7-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Cooper</u> ADDRESS <u>3724 Carroll Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arnold</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Arnold P.O.</i>		d. STREET ADDRESS <i>Arnold P.O.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Anita</i> Last <i>Kelley</i>		4. DATE OF DEATH Month <i>5-</i> Day <i>8</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 11th 1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Stephen Kelley</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Bronson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>4</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs Guy H. Kirby</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>150x gen carcinoma</i> DUE TO (b) <i>carcinoma of esophagus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i> <i>10 mos</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2 am</i> , 19 <i>5</i> , to <i>May 8</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 7</i> , 19 <i>58</i> , and that death occurred at <i>8:15 P. M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>S. Borssuck</i>		M.D. <i>Amos Zant</i>	
PHYSICIAN'S NAME (Type) <i>S. BORSSUCK</i>		<i>Annapolis Md</i>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5-11-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>May 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

DEATH CERTIFICATE		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS MARRIAGES	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05287

5267 CERTIFICATE OF DEATH

Item 9, Film G229, 5/16/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince George's</i>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis, Md</i>		LENGTH OF STAY (in this place) <i>2 yrs</i>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		<i>1614.2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Rest Home</i>				STREET ADDRESS <i>Calvert Rd -</i>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>DELLA MAY KILGOUR</i>				4. DATE OF DEATH (Month) <i>May</i> (Day) <i>6</i> (Year) <i>1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>May 15, 1877</i>	9. AGE last birthday <i>81</i> yrs.		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Patrick Cromartie</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Nelen Earle College Park Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>430.0 PUL MONARY / HEMORRHAGE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 HOURS</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>MAY 17</i>, 19 <i>58</i>, to <i>6 MAY</i>, 19 <i>58</i>, that I last saw the deceased alive on <i>6 MAY</i>, 19 <i>58</i>, and that death occurred at <i>10:45</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>Edmund S. Beck</i>				DATE SIGNED <i>5/16/58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>5/8/58</i>		NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	
				LOCATION (City, town, or county) <i>Colmar Manor Md</i>		(State)	
24. REC'D BY REGISTRAR <i>MAY 12 '58</i>		REGISTRAR'S SIGNATURE <i>Alfred...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>F. Guschi Sons Hyattsville Md</i>			
DATE				ADDRESS			

CERTIFICATE OF DEATH

FILE NO. 12345

1. NAME OF DECEASED

2. SEX

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

20. SIGNATURE OF DECEASED



21. SIGNATURE OF DECEASED

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CERTIFICATE OF DEATH

Reg. Dist. No. 05288

5312

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENBURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLENBURNIE</u>	
c. LENGTH OF STAY IN 1b <u>6 MO.</u>		d. STREET ADDRESS <u>3 BINKNEY RD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 BINKNEY RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>F.</u> Last <u>KIRGAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1881</u> 76 yrs.
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TOOL MAKER</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TOOL MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>E.L. KIRGAN CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOVOY KIRGAN</u>		14. MOTHER'S MAIDEN NAME <u>LIESETTE SCHMITZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-9614</u>	
17. INFORMANT <u>MRS NAOMI A. KIRGAN</u>		Address <u>3 BINKNEY RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency 20d Posterior Infarction</u> DUE TO (c) <u>Adenocarcinoma of Larynx 2 Carcinomatosis 4yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>58</u> , to <u>5/3</u> , 19 <u>58</u> that I last saw the deceased alive on <u>3/14</u> , 19 <u>58</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>113 7th Ave</u> DATE SIGNED <u>5/3/58</u>	
ACTUAL SIGNATURE <u>Leonard H. Flax M.D.</u>		PHYSICIAN'S NAME (Type) <u>Leonard H. Flax M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>5/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUNERAL DIRECTORS</u>		ADDRESS <u>4101 EDMONDSON AVE.</u>	
24a. REC'D BY REGISTRAR <u>MAY 6 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

5313

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY a.a.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN TB 3 Hr 50 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Patrick Middle Lee Last Kirk				4. DATE OF DEATH Month May Day 23 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1958	
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.		IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Father's name unknown				14. MOTHER'S MAIDEN NAME Clarice Kirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. N/A		17. INFORMANT Alfred L. Kirk Address Qtrs 2352 C Ft George G. Meade, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 23 May , 19 58 , to 23 May , 19 58 , that I last saw the deceased alive on 23 May , 19 58 , and that death occurred at 2:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE F. W. Lafferty M.D.							
PHYSICIAN'S NAME (Type) Frederick W. Lafferty, Capt, MC.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/27/58		22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Balto md.	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Holberton Funeral Home Inc.				24a. REC'D BY REGISTRAR DATE MAY 29 1958		24b. REGISTRAR'S SIGNATURE Quell	

2150181XVO 6306 Belair Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be returned to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED John J. Smith		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH Boston, Mass.		5. OCCUPATION Carpenter		6. MARITAL STATUS Married	
7. DATE OF DEATH Jan 15, 1925		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. DISEASE OR INJURY Coronary Artery Disease		12. PERIOD OF ILLNESS Several weeks	
13. SIGNATURE OF PHYSICIAN Dr. J. H. Brown		14. SIGNATURE OF REGISTRAR John Doe		15. SIGNATURE OF DECEASED (If living)	
16. SIGNATURE OF WITNESSES John Doe, Jane Smith		17. SIGNATURE OF DECEASED (If living)		18. SIGNATURE OF DECEASED (If living)	
19. SIGNATURE OF DECEASED (If living)		20. SIGNATURE OF DECEASED (If living)		21. SIGNATURE OF DECEASED (If living)	
22. SIGNATURE OF DECEASED (If living)		23. SIGNATURE OF DECEASED (If living)		24. SIGNATURE OF DECEASED (If living)	
25. SIGNATURE OF DECEASED (If living)		26. SIGNATURE OF DECEASED (If living)		27. SIGNATURE OF DECEASED (If living)	
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MASSACHUSETTS DEPARTMENT OF HEALTH - BULLETIN ONE
1925

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05290

5268

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>20.4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambrills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL County Hosp.</u>				d. STREET ADDRESS <u>DEFENSE Highway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Madge</u> Middle <u>A</u> Last <u>Leake</u>				4. DATE OF DEATH Month <u>5</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30th 1892</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MONTGOMERY, ALA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ARMSTRONG</u>				14. MOTHER'S MAIDEN NAME <u>LILLA JORDAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Lily A. Perry - Defense Highway</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> <u>484.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Insulin</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATH. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, PR Geo Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co - RIVERDALE, MD</u>				24a. REC'D BY REGISTRAR <u>Alfred</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7542004



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CERTIFICATE OF DEATH

05291

Reg. Dist. No.

5314

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA			
c. LENGTH OF STAY IN 1b 5 years				d. STREET ADDRESS Box 126, Rt 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 126, Rt 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERNARD Middle MATHEW Last LEAVY				4. DATE OF DEATH Month 5 Day 27 Year 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-1904	
				9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE WORKER				10b. KIND OF BUSINESS OR INDUSTRY SPONGE RUBBER FACT		11. BIRTHPLACE (State or foreign country) RICHMOND, VA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN MATHEW LEAVY				14. MOTHER'S MAIDEN NAME ALICE ALLISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 170-05-9138			
				17. INFORMANT Address ALICE LEAVY, Rt 2, Box 126, PASADENA			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LUNG CARCINOMA WITH METASTASES IN BONES OF VERTEBRAE & PELVIS 163X DUE TO (b) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from SEPTEMBER 27, 1958 to 5-1, 1958 , that I last saw the deceased alive on 5-1, 1958 , and that death occurred at 6:49 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Otto Vogel M.D. M.D.				ADDRESS (Street, city or town, state) Box 441-A PASADENA, Md			
DATE SIGNED 5-27-58							
PHYSICIAN'S NAME (Type) OTTO VOGEL M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran ADDRESS -3000 E. Baltimore Street				24a. REC'D BY REGISTRAR JUN 2 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5315

CERTIFICATE OF DEATH

05292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1515 Bruce Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louisa		4. DATE OF DEATH Month 5 Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Dyson		14. MOTHER'S MAIDEN NAME Elizabeth Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis with Renal Failure DUE TO (c) Hypertensive Cardiovascular-Renal Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and Blindness		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/30 , 19 58 to 5/8 , 19 58 , that I last saw the deceased alive on 5/8 , 19 58 , and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md.			
ACTUAL SIGNATURE Lionell McHenry Mapp, M. D.		M.D. Crownsville State Hospital, Md.	
PHYSICIAN'S NAME (Type) Lionell McHenry Mapp, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/13/58	
22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. R. ...		24a. REC'D BY REGISTRAR DATE MAY 15 '58	
ADDRESS ...		24b. REGISTRAR'S SIGNATURE ...	

CERTIFICATE OF DEATH

RECEIVED
BALTIMORE
MAY 11 1941

0-1

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1895</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>May 10, 1941</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Duration of illness: <u>2 weeks</u></p>		<p>10. Attending physician: <u>Dr. J. H. Jones</u></p>	
<p>11. Name of informant: <u>John J. Smith</u></p>		<p>12. Address: <u>123 Main St., Baltimore, Md.</u></p>	
<p>13. Signature of informant: <u>[Signature]</u></p>		<p>14. Signature of physician: <u>[Signature]</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5269

Item 8 Film 0229 5-19-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

05293

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 Ferndale (Glen Burnie, P.O.)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Lee</u> Last <u>May</u>				4. DATE OF DEATH Month <u>May</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27/1872</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Unknown) Loving</u>	
14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Lee Gardner</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Arteriosclerotic nephrosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>58</u> , to <u>5/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/9</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Holsman</u> M.D.				ADDRESS (Street, city or town, state) <u>68 Franklin St.</u>		DATE SIGNED <u>5/9/58</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>May 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Twp, Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Singleton</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>		24c. DATE <u>MAY 15 58</u>		24d. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05294

5316

<p>1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seyern, RD</u></p>				<p>c. LENGTH OF STAY IN 1b <u>Life</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Quarterfield Road</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>TRENT</u> Middle <u>MARGARET</u> Last <u>LEIGHT</u></p>				<p>4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1958</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Aug. 11, 1908</u></p>	
<p>9. AGE (In years last birthday) <u>49</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder (ret.)</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Standard Gas Stove Company</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>George H. Benton</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Agnes Bortner</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>216-05-4694</u></p>		<p>17. INFORMANT <u>Mr. John R. Leight</u> Address <u>Same As #2</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident (Cholesterol)</u> 331X DUE TO <u>Generalized Arterio-sclerosis Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 1/2</u> DUE TO (c)</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> m. <u>19</u> p. m.</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>1/30</u>, 19<u>51</u>, to <u>5/12</u>, 19<u>58</u>, that I last saw the deceased alive on <u>5/19</u>, 19<u>58</u>, and that death occurred at <u>8:22</u> M., from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>JEANNETTE R. HEGHINIAN</u> M.D.</p>				<p>ADDRESS (Street, city or town, state) <u>2212 SOUTH ROAD, BALTO. 9, MD.</u> DATE SIGNED <u>9/16</u></p>			
<p>PHYSICIAN'S NAME (Type) <u>JEANNETTE R. HEGHINIAN</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>May 15, 1958</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. H. H.</u></p>				<p>ADDRESS <u>Glen Burnie, Md.</u></p>		<p>24a. REC'D BY REGISTRAR DATE <u>MAY 19 '58</u></p>	
				<p>24b. REGISTRAR'S SIGNATURE <u>Alfred</u></p>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALABAMA STATE DEPARTMENT OF HEALTH-BIRMINGHAM

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43

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05295

5270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>aa General</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>140 Murray Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>B.</u> Last <u>Lincoln</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min. <u>65</u>	IF UNDER 24 HRS. Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min. <u>65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Mech Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.F.S.</u>	11. BIRTHPLACE (State or foreign country) <u>Keene N.H.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph A Lincoln</u>	
14. MOTHER'S MAIDEN NAME <u>Mabel Welch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gertrude R. Lincoln</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Myocardial Cardio Vascular Renal Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>442x</u> DUE TO <u>442x</u> (c) <u>442x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/20</u> , 19 <u>58</u> to <u>5/25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/25</u> , 19 <u>58</u> , and that death occurred at <u>1304 N.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Edward Beck</u> M.D. <u>e</u>			
ACTUAL SIGNATURE <u>Edward Beck</u>		PHYSICIAN'S NAME (Type) <u>Edward Beck</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>
22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u> ADDRESS <u>Sno Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>MAY 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL HISTORY	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTRY		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
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97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, this _____ day of _____, 19____.

REGISTERAR

DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5271

CERTIFICATE OF DEATH

Reg. Dist. No. 05296

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md				c. LENGTH OF STAY IN 1b 2 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena Md Chelsa Beach				d. STREET ADDRESS 6 street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beatrice Middle E. Last Maske				4. DATE OF DEATH Month May Day 4 Year 1958			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1892		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Mc Namara				14. MOTHER'S MAIDEN NAME Sarah E Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Nabel Coeyman Address Pasadena Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 5 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/13 , 19 58 , to 5/14 , 19 58 , that I last saw the deceased alive on 5/14 , 19 58 , and that death occurred at 12:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 44 Rockgate Ave Annapolis Md DATE SIGNED 5/14/58							
ACTUAL SIGNATURE Edward S Beck		PHYSICIAN'S NAME (Type) Edward S Beck					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE MAY 12 1958		24b. REGISTRAR'S SIGNATURE Albert Seuch	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5272

CERTIFICATE OF DEATH

Reg. Dist. No. 05297

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Carola Mason</u>				4. DATE OF DEATH Month Day Year <u>May 11 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14th 1896</u>	9. AGE (In years last birthday) <u>61</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sir John Throgmorton Middlemore</u>				14. MOTHER'S MAIDEN NAME <u>Lady Mary Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs Charles S. Bell</u>		(2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibromyxosarcoma of ovary</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 wks</u> DUE TO (c) <u>6 wks</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>58</u> , to <u>May 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Hedeman</u>				ADDRESS (Street, city or town, state) <u>68 Franklin St Annapolis Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN</u>				DATE SIGNED <u>5/11/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayles Sr</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 13 58</u>		24b. REGISTRAR'S SIGNATURE <u>Outland</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: All death certificates are completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE [Faint text, possibly "June 1, 1925"]</p>	
<p>9. NAME OF SPOUSE [Faint text, possibly "Jane Doe"]</p>		<p>10. DATE OF DEATH [Faint text, possibly "Dec 1, 1945"]</p>	
<p>11. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>12. CAUSE OF DEATH [Faint text, possibly "Heart disease"]</p>	
<p>13. MEDICAL HISTORY [Faint text, possibly "Hypertension"]</p>		<p>14. PRESENT ILLNESS [Faint text, possibly "Stroke"]</p>	
<p>15. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>16. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>17. NAME OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]</p>		<p>18. NAME OF REGISTRAR [Faint text, possibly "John Doe"]</p>	
<p>19. ADDRESS OF PHYSICIAN [Faint text, possibly "123 Main St"]</p>		<p>20. ADDRESS OF REGISTRAR [Faint text, possibly "456 Main St"]</p>	
<p>21. CITY OF PHYSICIAN [Faint text, possibly "Baltimore"]</p>		<p>22. CITY OF REGISTRAR [Faint text, possibly "Baltimore"]</p>	
<p>23. STATE OF PHYSICIAN [Faint text, possibly "Md"]</p>		<p>24. STATE OF REGISTRAR [Faint text, possibly "Md"]</p>	
<p>25. COUNTY OF PHYSICIAN [Faint text, possibly "Baltimore"]</p>		<p>26. COUNTY OF REGISTRAR [Faint text, possibly "Baltimore"]</p>	
<p>27. ZIP CODE OF PHYSICIAN [Faint text, possibly "21201"]</p>		<p>28. ZIP CODE OF REGISTRAR [Faint text, possibly "21201"]</p>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, this 1st day of December, 1945.

JOHN DOE, REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendship</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Alice Maynard</u>		4. DATE OF DEATH Month Day Year <u>May 11 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 1885</u>
9. AGE (In years, last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Starks</u>		14. MOTHER'S MAIDEN NAME <u>Louise Booze</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mazora Willis Friendship</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>172x Carcinoma corpus uteri</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>generalized metastases</u> (c) <u>generalized metastases</u> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>172x</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-15-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>B. Arundel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Sewell P. B. Frederick, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 19 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. J. Seach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARSHALL STATE DEPARTMENT OF HEALTH-2-AVAILABLE TO
MEDICAL EXAMINERS-CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5273

CERTIFICATE OF DEATH

05299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belvedere Hgts</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		d. STREET ADDRESS <i>1171</i>	
3. NAME OF DECEASED (Type or print) First <i>Catalina</i> Middle <i>Messick</i> Last <i>Messick</i>		4. DATE OF DEATH Month <i>5-</i> Day <i>14</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-58</i>
9. AGE (In years last birthday) <i>2</i>		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i> Hours <i>2</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Carroll J. Messick</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth R. Worthington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Carroll J. Messick</i>	
17. INFORMANT <i>(2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>757.3</i> DUE TO <i>CONGENITAL Absence of Kidneys</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(c)</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>(b)</i> <i>(c)</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>MAY 14</i> , 19 <i>58</i> , to <i>MAY 14</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>MAY 14</i> , 19 <i>58</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Francis D. Codd</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>SEVERNA PARK MD 5-18-58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 17-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Marys Court</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sr</i>		24a. REC'D BY REGISTRAR <i>MAY 20 '58</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

2063324 XV3

CERTIFICATE OF DEATH

2973

<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>		<p>DATE OF BIRTH <i>Jan 15 1880</i></p>		<p>PLACE OF BIRTH <i>Massachusetts</i></p>	
<p>RESIDENCE <i>123 Main St, Boston</i></p>		<p>DATE OF DEATH <i>Jan 20 1925</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>MANNER OF DEATH <i>Natural</i></p>	
<p>DIAGNOSIS <i>Myocardial Infarction</i></p>		<p>DATE OF EXAMINATION <i>Jan 22 1925</i></p>		<p>TIME OF EXAMINATION <i>11:00 AM</i></p>		<p>PLACE OF EXAMINATION <i>Home</i></p>		<p>CAUSE OF EXAMINATION <i>Death</i></p>		<p>MANNER OF EXAMINATION <i>Natural</i></p>	
<p>DATE OF INTERMENT <i>Jan 22 1925</i></p>		<p>TIME OF INTERMENT <i>11:00 AM</i></p>		<p>PLACE OF INTERMENT <i>Home</i></p>		<p>CAUSE OF INTERMENT <i>Death</i></p>		<p>MANNER OF INTERMENT <i>Natural</i></p>		<p>DATE OF BURIAL <i>Jan 22 1925</i></p>	
<p>DATE OF CREMATION <i>Jan 22 1925</i></p>		<p>TIME OF CREMATION <i>11:00 AM</i></p>		<p>PLACE OF CREMATION <i>Home</i></p>		<p>CAUSE OF CREMATION <i>Death</i></p>		<p>MANNER OF CREMATION <i>Natural</i></p>		<p>DATE OF BURIAL <i>Jan 22 1925</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5318

CERTIFICATE OF DEATH

Reg. Dist. No.

05300

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 39 S. Bond Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marie		4. DATE OF DEATH Month 5 Day 12 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/99
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure with Cardiac Decompensation (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyelonephritis with Uremia - Chronic Brain Syndrome with Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4/12/58 , 19 58 , to 5/12 , 19 58 , that I last saw the deceased alive on 5/12 , 19 58 , and that death occurred at 8:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 5/13/58 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 5/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/16/58	22c. NAME OF CEMETERY OR CREMATORY CARVER MEM. PARK	22d. LOCATION (City, town, or county) (State) LAUREL Md.
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Elickson		24a. REC'D BY REGISTRAR N. CAROLINE ST.	24b. REGISTRAR'S SIGNATURE ALL

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05301

Reg. Dist. No.

5319

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>3 m 25 d</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charlie</u> Middle <u>Monroe</u> Last <u>Monroe</u>				4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>1905?</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				<u>Maryland</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Brain Tumor (Astrocytoma)</u> <u>193.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with CVA</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/28</u> , 19 <u>58</u> , to <u>5/23/</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/23/</u> , 19 <u>58</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Reissmann</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>5/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Reissmann</u>				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>War the Wain</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Alb...</u>	

MEDICAL CERTIFICATION

2

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10

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44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of birth: _____</p>	
<p>5. Place of birth: _____</p>		<p>6. Date of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	



MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON, MASS.
RECEIVED
JAN 12 1912

CERTIFICATE OF DEATH

Reg. Dist. No. 05302

5320

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANN ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVNDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARVNDALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2110 Goodwood Road</u>				d. STREET ADDRESS <u>2110 Goodwood Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Boland</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 17 1915</u>	9. AGE (In years last birthday) <u>43</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Lewellin Moore</u>				14. MOTHER'S MAIDEN NAME <u>MARY Mollie Windsor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-3020</u>		17. INFORMANT <u>Katherine Moore</u> Address <u>2110 Goodwood Glen Burnie, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Pulmonary Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Seminoma, Testicle Rt.</u> (c) <u>178X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3 mos.</u> <u>14 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MAL NUTRITION</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>57</u> , to <u>5/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>58</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.W. Prichard</u> M.D.				ADDRESS (Street, city or town, state) <u>715 Cotter Rd</u>		DATE SIGNED <u>5/18/58</u>	
PHYSICIAN'S NAME (Type) <u>P.W. PRICHARD MD</u>				<u>Glen Burnie Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-21-58</u>		<u>WASHINGTON NATIONAL</u>		<u>SUTLAND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Washington, DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05303

5274

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills</u>	
c. LENGTH OF STAY IN 1b <u>Few seconds</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH <u>May 30th. 1958</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Steven Moore</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>June 16, 1897</u>		9. AGE (In years last birthday) <u>60</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant herdsman.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jim Rex Moore</u>		14. MOTHER'S MAIDEN NAME <u>Julia Jarman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>220-16-7241</u>	
17. INFORMANT <u>U.S. Naval Academy Dairy, Gambrills, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		22d. LOCATION (City, town, or county) (State) <u>Anson County N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Leavitt Jr.</u> ADDRESS <u>Wadesboro, N. C.</u>		24a. REC'D BY REGISTRAR <u>UN 9 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Leavitt Jr.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5273

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is partially filled out with handwritten text and includes checkboxes for various conditions.

1. PATIENT INFORMATION

2. CAUSE OF DEATH

3. EXAMINER'S SIGNATURE

4. WITNESSES

5. OTHER INFORMATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Any certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05304

CERTIFICATE OF DEATH

5321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>				c. LENGTH OF STAY IN TB <i>37 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <i>Lothian</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>James Henry Moreland</i>				4. DATE OF DEATH Month Day Year <i>May 2 1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/29/98</i>	
9. AGE (In years last birthday) <i>59</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Bristol Md.</i>		12. CITIZEN OF WHAT COUNTRY? Months Days Hours Min.	
13. FATHER'S NAME <i>Wm E. Moreland</i>				14. MOTHER'S MAIDEN NAME <i>Marytha Moreland</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>218-14-2185</i>		17. INFORMANT <i>Allen Moreland</i> Address <i>Lothian Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cancer of the stomach</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>151x</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Lothian</i>				20g. (County) <i>md</i>		20h. (State) <i>md</i>	
21. I certify that I attended the deceased from <i>2/1</i> , 19 <i>58</i> , to <i>5-2</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-1</i> , 19 <i>58</i> , and that death occurred at <i>6 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Emily H. Wilcox</i>				ADDRESS (Street, city or town, state) <i>Lothian, Md.</i>		DATE SIGNED <i>5-3-58</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/4/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MT Zion</i>		22d. LOCATION (City, town, or county) (State) <i>Lothian Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Gaudy Salisbury Md</i>				24a. REC'D BY REGISTRAR DATE <i>MAY 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Deborah</i>	

5275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrells</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>Box 116</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Wayne Musick</u>		4. DATE OF DEATH Month Day Year <u>May 13 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-58</u>
9. AGE (In years last birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence D. Musick</u>		14. MOTHER'S MAIDEN NAME <u>Sheila Yeglist</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clarence D. Musick</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congenital Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>754.5</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While o. m. Not while o. m. <input type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 13, 1958</u> , to <u>May 13, 1958</u> , that I last saw the deceased alive on <u>May 13, 1958</u> , and that death occurred at <u>2:06 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edmond J. Bennett</u> M.D.		ADDRESS (Street, city or town, state) <u>Gambrells Md</u> DATE SIGNED <u>5-14-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 19 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063201XV5

5276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Jr</u> Last <u>Neimiller</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 17th 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Neimiller</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Linex B. Neimiller</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute dilatation of the heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Jan 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> DATE SIGNED <u>5/23/58</u>							
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.				PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON - ANNAPOLIS - M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nethercrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5322

CERTIFICATE OF DEATH

Reg. Dist. No.

05307

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT MEADE				c. LENGTH OF STAY IN 1b 17 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL				d. STREET ADDRESS QTRS 2324-C and Bldg 2444			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GUY Middle Eugene Last PACKER				4. DATE OF DEATH Month May Day 27 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 June 1922		9. AGE (In years lost birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 27 Days 27 Hours 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U S ARMY		11. BIRTHPLACE (State or foreign country) WYMORE, NEB.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clyde Packer				14. MOTHER'S MAIDEN NAME Sada Phillipp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1942 -1958		17. INFORMANT MEDICAL EXAMINATION FOR REENLISTMENT FT MEADE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arteriosclerosis, severe 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) sudden							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 9. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:13 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph H. Williams				ADDRESS (Street, city or town, state) 215 A.H. Fort George B. Meade, Md.			
PHYSICIAN'S NAME (Type) JOSEPH H. WILLIAMS, CAPT, MC				DATE SIGNED			
22a. TIME OF CREMATION REMOVAL (Specify) 6/2/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Kendry Mortuary		22d. LOCATION (City, town, or county) (State) Marionville, Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Woberton Funeral Home, Inc.				ADDRESS 6306 - Belair Rd, Baltimore - 6 - Md		24a. REC'D BY REGISTRAR DATE JUN 2 '58	
				24b. REGISTRAR'S SIGNATURE W. J. Leach			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate is to be attached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5277

CERTIFICATE OF DEATH

05308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A. C. C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis 10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Gen. Hosp.</i>		d. STREET ADDRESS <i>105 1/2 Tucker St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Sharyl</i> Middle <i>Lynn</i> Last <i>Poland</i>		4. DATE OF DEATH Month <i>May</i> Day <i>15</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 15 1958</i>
9. AGE (In years last birthday) yrs. <i>5</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>5</i> Days <i>5</i> Hours <i>5</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>	
13. FATHER'S NAME <i>Harold Poland</i>		14. MOTHER'S MAIDEN NAME <i>Jeanette Washington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Harold Poland</i>	
17. INFORMANT <i>Harold Poland</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atelectasis</i> <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumatury</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/15</i> , 19 <i>58</i> , to <i>5/15</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/15</i> , 19 <i>58</i> , and that death occurred at <i>5:45</i> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>69 FRANKLIN ST ANNAPOLIS, MD</i> DATE SIGNED ACTUAL SIGNATURE <i>Robert A. Riley Jr.</i> M.D. PHYSICIAN'S NAME (Type) <i>ROBERT A. RILEY JR</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5-19-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Mem.</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Son Annapolis MD.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAY 20 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alb. Leach</i>	

MEDICAL CERTIFICATION

2063161XV2

5323

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Shadyside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Wesley Proctor</u>		4. DATE OF DEATH Month <u>MD4</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23 1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES</u>		14. MOTHER'S MAIDEN NAME <u>Harriet A Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry Proctor Shadyside Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Heart Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - truncation</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/14</u> , 19 <u>58</u> , to <u>5/16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>58</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>Shadyside, Md.</u> DATE SIGNED <u>5/16/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>5/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Shadyside</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burned Hardisty Baltimore Md</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JUN 6 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		MALE		39		JAN 5 1928		MOBILE, ALABAMA	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
MEMBER OF CONGRESS		HEART DISEASE		NATURAL		AT HOME		10:30 PM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. NAME OF HOSPITAL		17. NAME OF CITY		18. NAME OF STATE		19. NAME OF COUNTY		20. NAME OF DISTRICT	
[Blank]		BALTIMORE		MARYLAND		BALTIMORE		[Blank]	
21. NAME OF FUNERAL HOME		22. NAME OF CEMETERY		23. NAME OF CHURCH		24. NAME OF SYNAGOGUE		25. NAME OF OTHER PLACE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 7, Film G229, 5/16/58
 5324
 CERTIFICATE OF DEATH

05310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u>		c. LENGTH OF STAY IN 1b <u>4/17/58</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brownsville State Hospital</u>		d. STREET ADDRESS <u>1705 Brinkley Street</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First Middle Lost		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1885</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Month <u>4</u> Days <u>20</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Law carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Quinn Sr.</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis and chronic brain syndrome</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>58</u> , to <u>5/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/10/58</u> , 19 <u>58</u> , and that death occurred at <u>11:10</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. Benedict M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Brownsville State Hospital</u> <u>5/10/58</u>	
PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		ADDRESS <u>Crownsville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>	22d. LOCATION (City, town, or county) (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George W. Nelson</u>		ADDRESS <u>1348 N. Calhoun</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al L. Smith</u>	

John [illegible]

[illegible]

Greenwich State Hospital

Black

1918

John [illegible]

Greenwich State Hospital

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John [illegible]

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Greenwich State Hospital

Greenwich State Hospital

1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No.

05311

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Pulaski	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 2 y. 9 m.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Children's Center (Federal Institution)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BASCUME L.		d. STREET ADDRESS Route 2 Box 81	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/10/16	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Pulaski County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel H. Roope		14. MOTHER'S MAIDEN NAME Lucy Albert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army		16. SOCIAL SECURITY NO.	
17. INFORMANT E. R. Alley (brother-in-law)		Address Dublin, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gunshot wound of head 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head	
20c. TIME OF INJURY Month, Day, Year 5/25 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Laurel (County) A.A. County (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-26-58	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) PULASKI, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 27 '58 24b. REGISTRAR'S SIGNATURE Dee H. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05312

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. LENGTH OF STAY IN lb <u>6 years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 406 Maple Avenue.</u>		d. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>John Andrew Schultz</u>		4. DATE OF DEATH May 30th, 1958	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/93</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>BoilerMaker.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Andrew Schultz.</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Navy First World War.</u>		16. SOCIAL SECURITY NO. <u>173-10-7981</u>	
17. INFORMANT <u>Mrs. Agnes Ruth Schultz (wife)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/30/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whitted Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Weaverville, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hopping</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '58</u>	
ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Albert J. Hopping</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

3306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

3/1/58
Hopkins and Alexander, Glen Burnie, Md.
Investigator's Name: _____
Investigator's Address: _____
Investigator's Phone: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5327

CERTIFICATE OF DEATH

05313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 12/18/57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 3032 CENTRAL AVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSTOWN STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First Middle Last SCURRY		4. DATE OF DEATH May 29 1958 Month Day Year	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 8 1927
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10b. KIND OF BUSINESS OR INDUSTRY FLORIDA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Scurry		14. MOTHER'S MAIDEN NAME Fanny Scurry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister Address John Rennie P. Box 309			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STATUS EPILEPTICUS DUE TO (c) EPILEPSY - CNS SYPHILIS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026x			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/18 , 19 57 to 5/29 , 19 58 , that I last saw the deceased alive on 5/24/58 , 19 58 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CROWNSTOWN STATE HOSPITAL DATE SIGNED May 29 1958			
ACTUAL SIGNATURE L. Benedict M.D.		M.D. CROWNSTOWN STATE HOSPITAL	
PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		ADDRESS CROWNSTOWN, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/3/58	22c. NAME OF CEMETERY OR CREMATORY MARLEY NECK	22d. LOCATION (City, town, or county) (State) ARUNDEL Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Isaiah L. Brown ADDRESS 108 W MONTGOMERY ST		24a. REC'D BY REGISTRAR 4 '58 24b. REGISTRAR'S SIGNATURE Isaiah L. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05314

5328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 4yr. 5m. 25d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 1712 W. North Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Augusta Middle Lydia Last Smith		4. DATE OF DEATH Month 5 Day 1 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/93
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1	11. IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure and Cardiac Decompensation 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) Pyelonephritis and Senility with Uremia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July, 19 56 to May 1, 19 58 , that I last saw the deceased alive on May 1, 19 58 , and that death occurred at 8:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Maryland DATE SIGNED _____ ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville State Hospital, Maryland			
22a. REMOVAL (Specify) Removal 5-5-1958 24. of 4nd.		22b. DATE THEREOF 5-5-1958	
22c. NAME OF CEMETERY OR CREMATORY Balto. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese - Annapolis		24a. REC'D BY REGISTRAR 7 '58	
24b. REGISTRAR'S SIGNATURE William Reese			

CERTIFICATE OF DEATH

6532

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

Dr. J. H. [illegible]

21

Dr. J. H. [illegible]
[illegible] - [illegible]

5278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Severna Park, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>				d. STREET ADDRESS <u>1010 Annapolis Blvd</u> <u>4 lanes Magnolia Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Stinchcomb</u> Last <u>Stinchcomb</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 1, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>8</u> Days <u>4</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Steven Waters</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Son, Samuel Stinchcomb</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>1954</u> , 19 <u></u> , to <u>1958</u> , 19 <u></u> , that I last saw the deceased alive on <u>5-24-58</u> , 19 <u>58</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park 5-25-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>				Severna Park Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) <u>Howard Co, Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>MAY 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shoreham Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALDEMAR</u> <u>STRAUSS</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>13</u> , 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>48</u> yrs.
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Strauss</u>		14. MOTHER'S MAIDEN NAME <u>Tilda Strauss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>W. W. II</u>	
17. INFORMANT <u>A.A. Co Police Edgewater Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hose attached to exhaust of auto into front door</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hose attached to exhaust of auto into front door</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>XX</u> p. m. <u>5/11/58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Shoreham Beach Anne Arundel Md.</u>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Unknown</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenhame</u>		22d. LOCATION (City, town, or county) (State) <u>Boston MASS.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial Society</u>		24a. REC'D BY REGISTRAR <u>58</u>	
ADDRESS <u>Burial Society</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G229 6-2-58 et

5279

CERTIFICATE OF DEATH

05317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>183 Prince Geo St</u>				d. STREET ADDRESS <u>183 Prince George St</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>E.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>21</u> - Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-1870</u>		9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Bernard Ludholtz</u>				14. MOTHER'S MAIDEN NAME <u>Stretchen Bailer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Martha T. Adams</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of large bowel</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of large bowel</u> DUE TO (c) <u>Carcinoma of large bowel</u>						INTERVAL BETWEEN ONSET AND DEATH <u>177</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>5/21, 1958</u> , that I last saw the deceased alive on <u>5-21-1958</u> , and that death occurred at <u>11:05 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>65 SHAW ST. ANNAPOLIS, MD.</u> DATE SIGNED <u>John M. Taylor</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Houch</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Passadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Passadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				h. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Esther Middle Tolliver Last Tolliver				4. DATE OF DEATH Month May Day 25 Year 19 58			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Madison Co., Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Tolliver				14. MOTHER'S MAIDEN NAME Betty Tolliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William Brown Address 4222 Evans Chapel Road			
18. CAUSE OF DEATH [Enter only one cause per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac decompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Hypertension, moderate, essential						INTERVAL BETWEEN ONSET AND DEATH 2 weeks several years several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1, 1958 , to May 25, 1958 , that I last saw the deceased alive on May 23, 1958 , and that death occurred at 7:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. M. McLaughlin M.D.				ADDRESS (Street, city or town, state) Passadena P.O. Maryland DATE SIGNED May 25, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802 Madison Avenue				24a. REC'D BY REGISTRAR DATE MAY 28 1958		24b. REGISTRAR'S SIGNATURE Dee. L. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name (Print)		Age (Years)	
Sex		Race	
Date of Birth		Place of Birth	
Date of Death		Place of Death	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Hospital Name		City and State	
Date of Report		Reported by	
U.S.A.		U.S.A.	

5331

CERTIFICATE OF DEATH

Reg. Dist. No.

05319

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gradesville</i>				c. LENGTH OF STAY IN 1b <i>30 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ODEN EDWARD TUCKER</i>				4. DATE OF DEATH <i>MAY 15 1958</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Davidsonville Md.</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>William Tucker</i>				14. MOTHER'S MAIDEN NAME <i>R. Igoung</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>213 05 0069</i>			
17. INFORMANT <i>Frances Tucker</i>				Address <i>Gradesville Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial failure</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>chronic C.V.A. disease</i> DUE TO (c) <i>chronic nephritis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April 26</i> , 1958, to <i>May 15</i> , 1958, that I last saw the deceased alive on <i>May 15</i> , 1958, and that death occurred at <i>2:05 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Emily H. Huber</i> M.D.				ADDRESS (Street, city or town, state) <i>Sutton, Md.</i> DATE SIGNED <i>5-17-58</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>5/18/58</i>		<i>Tucker</i>		<i>Gradesville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel Handley</i> ADDRESS <i>Gradesville Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 6 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05320

Reg. Dist. No.

5332

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Unknown b. COUNTY AD Unknown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b X Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) UNKNOWN BABY		4. DATE OF DEATH Month May Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH newborn
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Asphyxia 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Unknown	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 5/5/58	
22a. BURIAL (CREMATION) REMOVAL (Specify)		22b. DATE THEREOF 5/5/58	
22c. NAME OF CEMETERY OR CREMATORY city morgue		22d. LOCATION (City, town, or county) (State) 700 FLEET ST.	
23. FUNERAL DIRECTOR'S SIGNATURE R. S. FISHER, M.D., 700 FLEET ST.		24. REGISTAR'S SIGNATURE DATE MAY 7 '58	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

AND COUNTY
V.

TO BE
FILED IN
THE
OFFICE OF THE
STATE
HEALTH
DEPARTMENT

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5555

DATE OF DEATH

PLACE OF DEATH

DECEASED

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

TIME

AGE
SEX
RACE
RELIGION
MARRIAGE

EDUCATION
OCCUPATION
HISTORY

PHYSICAL EXAMINATION

MENTAL EXAMINATION

TESTS
X-RAY
LABORATORY

TESTS
X-RAY
LABORATORY

TESTS
X-RAY
LABORATORY

TESTS
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LABORATORY

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X-RAY
LABORATORY

5280

CERTIFICATE OF DEATH

05321
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.C.</u> b. COUNTY <u>Duplin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Warsaw</u> 70 X - 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Robert Earle Wall</u> First Middle Last				4. DATE OF DEATH Month <u>5-</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-1887</u> 70 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR: Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Buck Lodge Md</u>		11. BIRTHPLACE (State or foreign country) <u>N.S.A</u>	
13. FATHER'S NAME <u>William Wall</u>				14. MOTHER'S MAIDEN NAME <u>Dade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Nena J. Wall Warsaw N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>10 YRS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PEPTIC ULCER</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 MAY, 1958</u> , to <u>29 MAY, 1958</u> , that I last saw the deceased alive on <u>29 MAY, 1958</u> , and that death occurred at <u>540 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city or town, state) <u>41 Southgate AVE</u>		DATE SIGNED <u>5/29/58</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S BECK</u>				ANNAPOLIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pinecrest</u>		22d. LOCATION (City, town, or county) (State) <u>Warsaw N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Quinn-McGowan & Son, Warsaw N.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Lash</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7520

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>	
<p>3. AGE _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. DATE OF DEATH _____</p>	
<p>7. TIME OF DEATH _____</p>		<p>8. PLACE OF DEATH _____</p>	
<p>9. CAUSE OF DEATH _____</p>		<p>10. MANNER OF DEATH _____</p>	
<p>11. SIGNATURE OF PHYSICIAN _____</p>		<p>12. SIGNATURE OF REGISTRAR _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>	
<p>15. SIGNATURE OF NEXT OF KIN _____</p>		<p>16. SIGNATURE OF BURIAL SOCIETY _____</p>	
<p>17. SIGNATURE OF FUNERAL HOME _____</p>		<p>18. SIGNATURE OF CHURCH _____</p>	
<p>19. SIGNATURE OF CEMETERY _____</p>		<p>20. SIGNATURE OF OTHER _____</p>	

THIS IS A PRELIMINARY REPORT AND SHOULD NOT BE USED FOR ANY OTHER PURPOSE.

THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, RECEIVED THIS REPORT ON _____ 19____.

5333

CERTIFICATE OF DEATH

05322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Margate Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Margate Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lamar Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Arthur</i> Middle <i>Watson</i> Last <i>Watson</i>		4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/20/1874</i>
9. AGE (In years, lost birthday yrs.) <i>84</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Watchman</i>	
11. BIRTHPLACE (State or foreign country) <i>California</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>World War</i>	
17. INFORMANT <i>Mrs Catherine Wheelzel</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Cardio vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cardio vascular Disease</i> (c) <i>Cardio vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>2</i> <i>7</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Thurs</i> , 1958, to <i>May 16</i> , 1958; that I last saw the deceased alive on <i>May 16</i> , 1958, and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Henry J. Glusman</i> M.D.		2687 <i>Weston Ave</i>	
PHYSICIAN'S NAME (Type) <i>Henry J. Glusman</i>		<i>Waco</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>5/20/58</i>	<i>Holy Cross Cem</i>	<i>Ritchie Hwy Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan & Son</i>		ADDRESS <i>2111 N. Hollins St</i>	24a. RECEIVED BY REGISTRAR DATE <i>MAY 20 1958</i>
		24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05323

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Atlantis Gas Station(Boontown)</u>				d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Chester</u> Middle <u>Glenn</u> Last <u>Weed</u>			4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1909</u>		9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frank M. Weed</u>			14. MOTHER'S MAIDEN NAME <u>Florence A. Weed</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-2222</u>		17. INFORMANT <u>Harry Weed</u> Address <u>Odenton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) <u>stating the underlying cause lost.</u> DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5/31/58</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cemetery Episcopal ch</u>	
22d. LOCATION (City, town, or county) <u>Odenton Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Longtitt</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>					

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5335

CERTIFICATE OF DEATH

Reg. Dist. No. 05324

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6yr. 10m. 10d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Baltimore 3401-4			
3. NAME OF DECEASED (Type or print) Charles				4. DATE OF DEATH Month 5 Day 8 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James White				14. MOTHER'S MAIDEN NAME Martha			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Hemiplegia DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/6/55 , 19 58 , to 5/8/ , 19 58 , that I last saw the deceased alive on 5/8/ , 19 58 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Reissmann M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Maryland DATE SIGNED 5/8/58			
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.				Crownsville State Hospital, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5-9-58		22c. NAME OF CEMETERY OR CREMATORY St. of Md. Und. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, D-Anna, Md. ADDRESS				24a. REC'D BY REGISTRAR MAY 12 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

4 4

CERTIFICATE OF DEATH

5336

Reg. Dist. No. 05325

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>417 Pine Terrace</u>		d. STREET ADDRESS <u>1417 Pine Terrace</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur H. Whittington, Sr.</u>		4. DATE OF DEATH Month Day Year <u>May 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>De Driender (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. & P. Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Florence Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or status of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-0041</u>	
17. INFORMANT <u>Mrs. Annie Whittington</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr - 2 AM - 2:30 AM</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1951</u> , to <u>May 10, 1958</u> , that I last saw the deceased alive on <u>May 6, 1958</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew R. Sosnowski</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4016 Ritchie Hwy Baltimore 12 May 58</u>	
PHYSICIAN'S NAME (Type) <u>Andrew R. Sosnowski M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 13, 1958</u>	<u>Glen Haven Cems.</u>	<u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Whittington</u>		ADDRESS <u>Glen Burnie, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Andrew</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5281

CERTIFICATE OF DEATH

Reg. Dist. No. 05326

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beverly Beach</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U.S. General</i>				d. STREET ADDRESS <i>1 Mayo md</i>			
3. NAME OF DECEASED (Type or print) First <i>Walter P.</i> Middle <i>Winecoff</i> Last <i>Winecoff</i>				4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5</i>	9. AGE (In years lost birthday) <i>65</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Electrical Equip. Concord N.C.</i>		11. BIRTHPLACE (State or foreign country) <i>N. S.A.</i>	
13. FATHER'S NAME <i>Rev. J. E. L. Winecoff</i>				14. MOTHER'S MAIDEN NAME <i>Meta Gillon</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>68 Franklin</i>		17. INFORMANT Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>330x Spontaneous subarachnoid hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i>36 hrs.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Urinary retention due to benign prostatic hyperplasia</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>May 16, 1958</i> to <i>May 17, 1958</i> , that I last saw the deceased alive on <i>May 17, 1958</i> , and that death occurred at <i>11:45</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John L. Hedeman</i>				ADDRESS (Street, city or town, state) <i>68 Franklin Annapolis, Md.</i>		DATE SIGNED <i>5/18/58</i>	
PHYSICIAN'S NAME (Type) <i>JOHN L. HEDEMAN</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-21-58</i>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State) <i>Greensburg Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5282

CERTIFICATE OF DEATH

Reg. Dist. No. 05327

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVE Middle E. Last YOUNG		4. DATE OF DEATH Month MAY Day 5 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-94
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Francis S. Young	
14. MOTHER'S MAIDEN NAME Althaeretta Cranford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-38-7583		17. INFORMANT Mr Albert E. Young- 933 N. Linwood Ave, Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Operation for:- DUE TO (c) Carcinoma of cecum			INTERVAL BETWEEN ONSET AND DEATH 3 days 6 days ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-19-58 , 19____, to 5-5-58 , 19____, that I last saw the deceased alive on 5-5-58 , 19____, and that death occurred at 3:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 CATHEDRAL ST., ANNAPOLIS, MARYLAND DATE SIGNED 5-5-58			
ACTUAL SIGNATURE Jesse L. Wilkins M.D.		DATE SIGNED 5-5-58	
PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.		ANNAPOLIS, MARYLAND	
22a. BURIAL, CREMATION, REMQVAL (Specify) Burial	22b. DATE THEREOF May 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE MAY 8 '58	24b. REGISTRAR'S SIGNATURE Deed...

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5337

CERTIFICATE OF DEATH

05328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>ZELLA</u> First <u>Z.</u> Middle <u>ZEIGLER</u> Last		4. DATE OF DEATH <u>May</u> Month <u>5</u> Day <u>1958</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Director's Center (D.C.)</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Adolph Zeigler</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT <u>Family records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No Injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5, 1958</u> to <u>May 5, 1958</u> , that I last saw the deceased alive on <u>May 5, 1958</u> and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Wingfield</u>		DATE SIGNED <u>May 5, 1958</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>		M.D. <u>Laurel, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Martinsburg W. Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Davidson</u>		24a. REC'D BY REGISTRAR <u>May 14 '58</u>	
ADDRESS <u>Laurel Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Davidson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1917

NAME OF DECEASED: *William J. Smith*

AGE: *45*

SEX: *Male*

RACE: *White*

DATE OF DEATH: *April 15, 1917*

PLACE OF DEATH: *Home*

Cause of Death: *Heart Disease*

Signature of Physician: *Dr. J. H. Smith*

Signature of Registrar: *John D. Smith*